S. HRG. 103-373

ANTITRUST ISSUES IN THE HEALTH CARE INDUSTRY

HEARING

BEFORE THE

SUBCOMMITTEE ON
MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

MAY 7, 1993

Printed for the use of the Committee on Finance

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CONTENTS

OPENING STATEMENTS

COMMITTEE PRESS RELEASE

ADMINISTRATION WITNESS

CONGRESSIONAL WITNESS

PUBLIC WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL SUBMITTED

COMMUNICATIONS

ANTITRUST ISSUES IN THE HEALTH CARE INDUSTRY

FRIDAY, MAY 7, 1993

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:17 a.m., in room SD–215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV (chairman of the subcommittee) presiding.

Also present: Senators Baucus, Daschle, Chafee, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H–20, May 5, 1993]

FINANCE SUBCOMMITTEE ON MEDICARE TO HOLD HEARING ON ANTITRUST ISSUES IN HEALTH CARE INDUSTRY

WASHINGTON, DC—Senator John D. Rockefeller IV (D–WV), Chairman of the Committee on Finance Subcommittee on Medicare and Long Term Care, announced today that the subcommittee will hold hearings on antitrust issues in the health care industry.

The hearing is scheduled for *10:00 A.M. on Friday, May 7, 1993,* and will be held in room SD–215 of the Dirksen Senate Office Building.

In announcing the hearing, Senator Rockefeller stated: "There are many facets to the antitrust issue. This hearing will provide subcommittee members an opportunity to more fully explore these issues as we begin the task of reforming our health care system. There is a growing recognition that our health care delivery system needs to be substantially restructured to provide incentives for coordination and collaboration of health care services, and for preventative and primary care services. We can no longer afford the inefficiencies of duplication or financial incentives that encourage technology at the expense of prevention."

"This hearing will provide a starting point for figuring out whether legitimate barriers exist to the development of integrated health care networks or to lowering the costs of health care. A reformed care system will need local flexibility but, at the same time, consumers need to be assured affordable high quality health care."

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA, CHAIRMAN OF THE SUBCOMMITTEE

Senator ROCKEFELLER. Our first witness, Senator Metzenbaum, will be here. He is testifying downstairs but should be here by the time the Senator from Minnesota and I have finished our opening statements.

Actually, I wanted the Senator from Ohio to hear my opening statement. It was designed for him to hear. [Laughter.]

Would you like to go first? [Laughter.]

Senator DURENBERGER. It depends on how fast an hour it is this morning. Would you like me to? Seriously?

Senator ROCKEFELLER. Yes.

[The balance of Senator Rockefeller's opening statement appears on page 5.]

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Good morning, Mr. Chairman, and Howard Metzenbaum, wherever you are. Let me begin by saying something that sort of puts today's hearing in context.

First, I am very proud of the Chair of the subcommittee. This is another one of those hearings we have never had before and it is sort of like a sign of the times and this is not the first time that the Chairman has brought us together on a subject this committee does not, and the subcommittee, does not often deal with.

But it is because we are living in a time and we are faced with a challenge that we have not had before as a nation. We are all trying to figure out what managed competition is and how we are going to blend it into health care reform and what markets are, because we have never experienced them, in medicine.

So a few of us and other members of the subcommittee this morning came here to learn.

In my view, watching a market evolve in my own State without any help from the government, in fact, nothing but hindrance, I suppose, is that sound markets require informed consumer choice. They also require rewards to good producers and providers of care.

The sense of managed competition as I know it is that we will attempt to enhance consumer choice in two ways—one by providing information and two by allowing consumers to choose among health plans based on reliable price and quality information.

Without informed consumers and providers who are held accountable for results, rewarded for good results, you will never achieve the kind of cost containment that we insist on in our society and the high quality care that we have become so accustomed to.

We cannot do that without a market-based price mechanism. Medical markets work best when the best providers get all the business and when smart buyers are rewarded with better service and lower prices or value, as we call it.

The key to this is a price system that works. Under managed competition, consumers will choose among competing accountable health plans. Within each plan there may be hundreds of participating providers among whom a consumer may choose. The plan administrators guarantee that the providers they have selected meet quality standards.

In truth, choice is not threatened by this managed competition structure of a competing accountable health plan, but rather it is enhanced. The question for all of us is, are there changes that could be made and need to be made in the area of anti-trust policy and enforcement that would serve the purpose of protecting the value of consumer choice from anti-competitive behavior.

And if so, whose anti-competitive behavior do we need to be protected from? Anti-competitive practices cost our health care system

a lot of money, even in the current dysfunctional, or especially in the current dysfunctional system.

The most egregious examples are price fixing, boycotts, market allocations and buying arrangements. Ten percent of our National health care expenditures are estimated to be due to anti-competitive behavior. That amounted to $74 billion in 1991 or $790 million in the average family's health bill.

It is for this reason that those of us interested in reforming our Nation's health care system need to become more aware of the affect that anti-trust laws may have on providers and providers' perceptions of the laws, especially as we move to establish accountable health plans.

There is concern in this area that anti-trust laws prohibit the creation of integrated service network under certain circumstances, especially horizontal restraints of trade. But there is also concern that weakening the laws could complicate the negotiating process and cause managed competition ultimately to suffer.

Mr. Chairman, I do have several more pages to this statement, including some reference to the difficulty of the Group Health Association we had right here in this town in 1937, which was one of our first interesting anti-trust cases.

I will ask that my statement be made a part of the record, a statement by Senator Hatch, who cannot be with us today but would like to be, and some questions that Senator Hatch wants submitted for the record.

Senator ROCKEFELLER. All right, Senator. I was hoping you might finish your statement.

Senator DURENBERGER. I wondered if my colleague wanted to comment.

Senator CHAFEE. No, I will give you my time.

Senator ROCKEFELLER. There is plenty of time, Senator Chafee, proceed. [Laughter.]

[The prepared statements of Senators Durenberger and Hatch along with questions from Senator Hatch appear in the appendix.]

Senator CHAFEE. Well, I have no pearls of wisdom to give. I will say this, I have heard, and this is one of the reasons we are here today, anecdotal evidence about the facts of the anti-trust laws that prevent hospital mergers and prevent hospitals in small communities from working closer together, to save costs. It all seems not make a great deal of sense.

So I am looking forward to the testimony today and would be delighted to hear the balance of Senator Durenberger's comments.

Senator DURENBERGER. Mr. Chairman, John, I am not going to read the balance of my comments, but I would like to suggest a couple things, one in the current environment in which we see markets develop in my own State of Minnesota, and then some prospective comments that concern us as we try to define exactly what managed competition is.

The competition that exists in Minnesota is in the context of what economists call a dysfunctional marketplace. In other words, the signals are not very clear. The people are trying to do good, which is something that those of you who listen to Garrison Keeler are well aware is a trait that most of us possess out there.

And it has been an interesting time for all of us, watching efforts by employers in the Twin Cities in particular, to try to change the behavior of medical providers. And, we are going to have a witness here today from the Business Health Care Action Group talk about their efforts in Minnesota. But every time these forces come into the picture and try to aggregate the hospitals and the doctors and things like that, there is always the perceived threat of anti-trust violation.

We have closed in our Minneapolis-St. Paul community, about 2.2–2.3 million people, the equivalent of 10, 400-bed hospitals in the last year. But we are still at about, in the existing supply, a 46-percent occupancy.

So we still have a long way to go and people would argue we still have not reduced the cost growth as much as we could with that kind of an effort and principally because hospitals are competing at the high tech, high cost level; and the hospitals in our Twin Cities area are out buying up business and contracts and so forth all over the State.

But that is an interesting market at work, changing the supply in our community, which should drive down price but it does not yet because the signals are not there to do it.

Out in the rural areas, we have these interesting competitions like up in Fargo-Moorhead between two large medical groups, the Dakota Clinic and the Fargo Clinic. They have enhanced the care in all of these very rural areas in North Dakota and Minnesota by bringing in more and better doctors to all of these small communities.

Sometimes these physicians do not live in the community, sometimes they do and sometimes they come to visit. But it is these two clinics competing for business between themselves and competing with some of these solo practitioners that is actually making better medical care and better health care available to people in that area.

But again, they compete at who has the best cardiovascular unit or something like that or who can roll the MRI down the highway on an 18-wheeler and get it into some small town twice a week rather than once a week. So you see, good people are doing good things.

But without a stated objective that we want to raise the quality and lower the price at the same time, competition in that sense is not achieving some of the ends that our society would like to see changed.

In Sioux Falls, South Dakota, which serves the southwestern part of Minnesota, you have two large hospitals competing with each other; and I mean literally competing—out buying up administrative arrangements in small towns and making deals with doctors and things like that.

Now the Mayo Clinic as we all know is running out of business. So they are in Iowa trying to buy arrangements with doctors or in Wisconsin trying to do the same thing. Of course, people in Iowa and Wisconsin are getting a little apprehensive about that, particularly in Iowa. Somebody like Blue Cross/Blue Shield of Iowa, which is run by a former Republican Governor of that State is getting very nervous about somebody from outside the State coming in.

The temptation is to, you know, if we ever had epics or things like that, the temptation would be say, hey, wait a minute, we should have integrated service networks that are only Iowa networks. Is that good or is that bad? I read the same thing with North Dakota, where the Blue Cross/Blue Shield of North Dakota has kept the doctor payments about 20–25 percent higher in that State than Blue Cross/Blue Shield of Minnesota is paying doctors in Minnesota.

So why shouldn't Blue Cross/Blue Shield of Minnesota come across the border and help out the citizens of North Dakota? That is just to say, now that Howard is here, that markets do work if they get the right signals. And as we follow the flow, if we watch the Attorney General come into communities when doctors and hospitals try to combine to get efficiencies, he says, no, by the traditional standards we cannot do that.

So we maintain inefficiencies in the system because we are working off antitrust standards that have been somewhat antiquated.

Howard, I was just taking up a little time because I live across the street from you so you and I can talk about North Dakota and Iowa and Minnesota all the time, but Jay has something he wants you to hear. [Laughter.]

He has been yucking it up here.

Senator METZENBAUM. I want to explain to the committee that I just appeared before the Armed Services Committee to testify and to answer questions. It took longer than I expected. So I apologize, I certainly did not want to be disrespectful to this committee.

Senator ROCKEFELLER. We are very pleased that you are here and also very happy that we could work out this arrangement, Senator Metzenbaum. I worked this out because it is very clear that the Judiciary Committee does have jurisdiction over antitrust issues and yet it is of interest to us.

I did want to give an opening statement, Senator, and then go right to you, if that is okay.

Senator METZENBAUM. Sure.

Senator ROCKEFELLER. Okay. Thank you.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA, CHAIRMAN OF THE SUBCOMMITTEE [continuing]

Senator ROCKEFELLER. Obviously, we have called this meeting for the purpose of the discussion of antitrust. As the Senator from Minnesota said, I do not think there ever has been this kind of a meeting before.

The subject comes up constantly with health care providers, but I am not sure that our Finance Committee members are familiar with the subject. Some are lawyers, some are not. Some are more clear on this subject than others.

As I have said, it is very clear that the jurisdiction on antitrust law lies in the Subcommittee of the Judiciary Committee that Senator Metzenbaum chairs.

But I am more than pleased that he is here and agrees that in the context of comprehensive health care reform antitrust issues are an issue this subcommittee and indeed the full committee need

to know much more about. So this is for us a learning process as opposed to a legislating process.

Some health providers perceive the threat of antitrust litigation as one of the largest obstacles to reducing the waste and inefficiency in our Nation's health care system.

On the eve—with perhaps several more eves to come—of major health care reform, Americans are expecting solutions to the problems of cost containment and access. They want that. They demand that. They have a right for us to give that to them. They have been plagued by this for years and years and we have never been able to do anything here before now.

As the scaffolding of health reform begins to emerge, it is important to remember the changes will be based on new contractual relationships between the consumers, health care providers and insurers, all of which is now the subject of a lot of speculation. New contracts permit opportunity, and therefore, for change.

We must make sure that these opportunities lead to the most efficient use of our Nation's health care resources. Ensuring access and efficiency is, in fact, the heart of the antitrust issue. Antitrust law prevents organizations from setting up monopolies to hike the price of necessities of life, such as health care, to obtain a maximum profit, without any concern for social welfare.

And actually, in somewhat of an irony, it occurs to me that it was some great-grandfather of mine that really caused the whole antitrust movement to get going. [Laughter.]

Senator METZENBAUM. I thought about mentioning that and I decided it was inappropriate.

Senator ROCKEFELLER. Did you? [Laughter.]

And I really think you did. I really think there is quite a lot of irony here. [Laughter.]

May he rest in peace. He has done very well by me. [Laughter.]

In health care, antitrust law violators have attempted to fix prices and restrict the supply of services. That kind of activity impedes the cost effective delivery of health services. Why is an airing of antitrust issues regarding health care important, therefore?

The answer comes from the questions and the concerns raised by many health care providers and consumers across the country. To wit: Two hospitals want to buy an MRI together as a joint venture. A joint venture could lead to a violation of antitrust law.

Why don't the two hospitals simply buy their own MRI's? The reason is, both hospitals are short of cash. They want to keep their debt to a reasonable level and separately they may not have the patient volume to sustain the investment if they each were to get one.

So the two hospitals clearly want to give their patients the added benefit of a better diagnostic test. Would a joint venture justify scrutiny by an antitrust investigation? If the hospitals are to be investigated, what are the criteria and how would they know those criteria?

These are questions that need to be answered. The Rochester, NY health care system has been recognized as a model for the country. Rochester's leaders attribute much of their success to the development of a broad coalition of insurers, providers, businesses and consumers.

One specific success was the reduction of empty hospital beds. This is a clear illustration of restricting supply, a flag for potential antitrust legislation or investigations.

Are community health leaders at risk of antitrust law suits for activities that in retrospect clearly lead to a more efficient patient care system? When health leaders in the community meet to discuss improving health coverage and cost containment strategies, are they cooperating or colluding? These questions need to be answered.

A CEO of a Preferred Provider Organization (PPO) wants to negotiate the lowest price from a physician group they have determined to be of high quality. If the contract between the CEO and the physician group is exclusive, individuals outside the PPO are unlikely to be able to negotiate similar price discounts.

We must make sure that antitrust law is in sync with the current efforts for health care reform. We may want to encourage hospital joint ventures and community coalitions; and we must expect managed care to play an even larger role in the reformed delivery system that will increasingly rely on capitated payments.

Concerns regarding antitrust law and health care will grow, therefore. Antitrust health law requires more attention now than it has received in the past in the judgment of this Senator. Above all else, in our discussion of health reform we must remember that the purpose of antitrust law is to protect consumers from non-competitive behaviors and assure access to basic health services.

Consumers need to be protected from high prices and the costs of inefficiency in our health care system. At the same time every American citizen must have access to high quality, affordable health care.

With that predicate, and before I go to our distinguished visitor, I would ask whether the Senator from South Dakota and the Senator from Montana have comments they would like to make.

OPENING STATEMENT OF HON. THOMAS A. DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. Mr. Chairman, I applaud you for your leadership in this area and commend you for your comments just now. This is a very serious issue in rural America. I am sure Senator Durenberger has outlined the concerns that many of us in rural America have with regard to the lack of competition, the need for providers and facilities alike to find better ways with which to coordinate.

And if they are going to coordinate more effectively, they need to be assured that they are not going to have to deal with the antitrust difficulties that they continue to encounter. They are paranoid about dealing with the legal complexities that currently inhibiting them from cooperating and collectively dealing with these issues.

So a hearing like this is very helpful. I hope that we can figure out how to address this very serious problem, as we deal with comprehensive health care reform.

I thank you.

Senator ROCKEFELLER. Thank you, sir.

Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. We are all aware, Mr. Chairman, that health care costs are skyrocketing out of control. No one disputes that. In my State of Montana, for example, families are spending over $3,000 a year on health care, which is an increase of over 400 percent over the last decade. Health care providers in Montana tell me that competition is helping drive up our health care costs.

As you know, Montana is a very rural State. There just is not the population in most areas to support competition between multiple hospitals. As a result, many hospitals are trying to move away from competing with each other and towards working effectively together so that health resources are spent efficiently and effectively.

I am familiar with a study showing that competition among hospitals has reduced prices in places like California. But these markets have several hospitals competing in a single area, have a great deal of managed care, and have a significantly large population base.

In Montana, on the other hand, hospitals are competing over a very limited population base. When two hospitals in a small town compete for services, then each must raise prices so that they can cover either overhead with the revenue generated from this limited patient base. This is just wasteful.

It leads to higher prices and lower quality care. In these communities, I believe that hospitals should work together by sharing expensive equipment and even agreeing to coordinate which services facilities provide.

I have been impressed with the degree of cooperative among Montana hospitals thus far. Several hospitals have entered into joint ventures and are really trying to work together. But I know that some would go further if they were not worried about wanting to follow Federal antitrust laws.

I have been told that hospital mergers in rural areas are rarely, if ever, challenged by the Federal Government. That this is because the government recognizes that cooperation in many instances lowers the cost of health care and increases the quality of care.

Regardless of the number of cases actually challenged, I know that many hospitals, especially very small ones, sincerely worry about the Federal law. This perception exists and is a real one.

Despite the low number of actual challenges, they are still very concerned about the affect that this perception may have on the quality and cost of health care for Montanans.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you very much, Senator Baucus. I would like to remind both you and Senator Daschle again, and I pointed out to Senator Metzenbaum, that this is not really our jurisdiction. This is strictly the jurisdiction of the Senator from Ohio's Subcommittee of the Judiciary Committee.

But as I explained to him, this is so important in terms of the reform of health care that our knowledge base in this area is relatively weak in this area especially for those of us who are not lawyers. It is something that we need to know.

Senator Metzenbaum, we are honored and proud that you are here.

STATEMENT OF HON. HOWARD M. METZENBAUM, A U.S. SENATOR FROM OHIO

Senator METZENBAUM. Thank you very much, Mr. Chairman. I am very pleased to see so many members of the committee here with you this morning.

Let me start off by saying that we are not in contention with each other. As a matter of fact, I would say I am on your side. I am on your side with respect to the question of how do we figure out a way to reduce the cost of health care in this country. If it means that two rural hospitals should merge, this Senator does not really have any difficulty with that, nor does the government.

Because out of 225 hospital mergers that have occurred, there have been only seven that were at issue and, to the best of my recollection, I think that only one of those was a rural hospital.

The whole question that we have before us is, how do we bring down the cost of operating our hospitals, and our medical facilities, and our drug costs? Do we do it by stronger enforcement of our antitrust laws or by weakening our antitrust laws?

I chaired a hearing similar to this one last March. At that time, my Antitrust Subcommittee heard testimony which convinced me that American consumers could lose the battle to control the high cost of health care if we weaken our antitrust laws.

Today's hearing comes at an extremely opportune time. The Administration's Health Care Task Force is putting the final touches on its reform plan. We now know much more about how the new system will work. It is my view, and that of a number of expert witnesses from whom you will hear today, that strong antitrust laws will promote, not hinder, reform under the new health care system.

Doctors, hospitals and other entrenched special interests have launched a furious lobbying effort to weaken the antitrust laws. As you listen to their testimony today, I urge you to remember that if it had not been for vigorous antitrust enforcement, health care reform might not even be possible.

When health maintenance organizations, which are the prototype for the new provider networks, first attempted to enter the market, doctors and hospitals boycotted them—boycotted these new health maintenance organizations—because they saw them as a competitive threat. It took vigorous antitrust enforcement to defeat those collusive boycotts and to pave the way for HMO's to enter the market.

U.S. health care, one of the nation's largest HMO's has warned that, "weakening the antitrust laws would hurt competition in health care and cause prices to rise rather than moderate."

Doctors and hospital interest groups have a different view of the antitrust laws. The American Medical Association has made winning antitrust concessions for doctors one of its top lobbying priorities for health care reform.

They claim that doctors need antitrust relief to bargain with large buyers like HMO's. However, what they really mean is that they do not want HMO's forcing doctors to moderate their fees

which currently average $170,000 a year and, in some instances, are substantially in excess of that amount.

It is clear to me that the AMA could readily abuse antitrust concessions to undermine the development of new and innovative health networks. According to the Federal Trade Commission, the AMA has a history of opposing new health networks.

For example, when cost-cutting HMO's first tried to enter the market, the AMA advised its members, listen to this—the AMA told its members that it was unethical for doctors to contract with them. It also told doctors how to refuse to deal with the HMO's.

The FTC was forced to sue the AMA to reverse its policy of resisting HMO's. So I urge you to examine closely the antitrust concessions that the AMA is now seeking. They come with tainted hands. Their proposal could legalize the kind of collusive price fixing that the Justice Department prosecuted successfully in *United States* v. *Alston* in 1990.

In that case, a group of dentists conspired to raise their patients' co-payment fees. James Rill of the Bush Administration—in fact, the Bush Administration's antitrust chief—called the case, "a prime example of per se illegal conduct, warranting criminal prosecution that was wholly unrelated to the formation or operation of a bona fide joint venture." That was from James Rill, the head of the Antitrust Division in the last Administration.

It seems obvious to me that health care reform could be totally undermined by antitrust concessions which could legalize collusive price fixing by doctors.

The American Hospital Association has also made winning antitrust concessions a top lobbying priority.

I want to make a big distinction between the problems of some of the rural hospitals, to which I am totally sympathetic and to which I believe that there is a solution, and the position of the AHA.

The AHA claims that antitrust enforcement is chilling beneficial hospital mergers and joint ventures. When you look at the facts, their claims do not hold up. Since 1987 there have been over 225 hospital mergers. Of that number, only 22, less than 10 percent, have required intensive investigation and only 7 of the 225, about 3 percent, have been challenged.

Moreover, Federal authorities have not challenged a single joint venture or buying arrangement among hospitals. I want to emphasize that to you, Mr. Chairman. The Federal authorities have not challenged a single joint venture or buying arrangement, where hospitals get together to make their purchases.

This is hardly a record of antitrust enforcement run amuck. The fact is that the antitrust laws have been not used to block hospital deals that would benefit local communities by consolidating unused hospital beds, reducing wasteful competition for high technology equipment, such as MRI's, or saving a financially unstable hospital from closing its door.

Rather, the antitrust laws have been used to block mergers that were likely to increase prices and to keep HMO's out of the market.

I think that there might be something that could be done with respect to the matter of hospital mergers that could be helpful. I would be willing to explore that subject, to see if there is an expe-

dited procedure, a simpler procedure, a shorter time procedure that would not require rural hospitals or small hospitals to hire high-priced lawyers in order to find out whether or not they could merge. I think there could be some procedures worked out either with the Justice Department directly or by legislation if necessary.

Now there have also been claims that rural hospitals should be exempt from the antitrust laws. However, I believe that rural hospitals, like their urban counterparts, actually benefit from appropriate antitrust enforcement.

For example, in a March 12 letter to Majority Leader George Mitchell's staff, the Deputy Attorney General for the State of Maine warned that, "Competitive problems from hospital agreements are often more severe in rural States, such as Maine, than in large urban areas. "This is because the number of hospitals in rural areas is far less and consequently the parties to a joint agreement in rural States often include most or at times all of the hospitals in a particular market area."

Maine is not a big industrial State. Maine is not a State with large major cities. He is talking about rural hospitals in the State of Maine.

Rural hospitals should not be exempt from the antitrust laws. Those laws are flexible enough to permit rural hospital to merge or to enter into joint ventures when those deals benefit local consumers by cutting costs or eliminating unnecessary duplication.

I would urge you, Mr. Chairman, and members of your committee, to be aware of doctors and hospitals seeking antitrust concessions. In my view, the only change we should make in the antitrust law to speed health care reform is to repeal the McCarran-Ferguson exemption for health insurers. That change would prevent insurance cartels from fixing the price and the terms of health care coverage for consumers.

Let me address myself also to another area of this whole question of health care costs. That is, the whole question of the pharmaceutical companies that are also seeking exemptions from the antitrust laws.

They have come forward with some ideas to lower prices that they claim should be exempt from the antitrust laws. My own opinion is that the drug companies of this country have done as much to increase the costs of medical care on a proportionate basis as any other single segment of the industry.

If I had to figure out the actual order, I would not be able to say which group has done worse. But certainly the drug companies have been extremely, extremely difficult to deal with in terms of holding down health care costs. I think that any consideration of exemptions for hospitals, for physicians, or for pharmaceutical companies, would be inappropriate.

I do believe that we could work out an expedited procedure for rural hospitals or other hospitals for that matter, allow them to explore the possibility of going forward with a merger without heavy legal expenses and without unnecessary delay.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Metzenbaum.

[The prepared statement of Senator Metzenbaum appears in the appendix.]

Senator ROCKEFELLER. There is the matter of the perception of something and the reality of something. It is interesting how joint ventures of hospitals have not been challenged over the year; and then you have also indicated in your testimony that rural hospitals should not be exempt from antitrust laws.

You were also saying that you understand that rural hospitals have particularly difficult situations and you would understand their request for expedited procedures.

My question is, what do you mean by expedited procedures? If people are to embark on a project in a rural hospital, but they have the perception or the fear that they are going to be subject to antitrust laws how would that come to pass?

Often people do not do things for fear they will be singled out for attention.

Senator METZENBAUM. I understand.

Senator ROCKEFELLER. Therefore, they do not do things which might be perfectly acceptable.

Senator METZENBAUM. I think that could be handled by opinion letters. You can get an opinion letter from the Justice Department. And I think we get the Antitrust Department under its new leadership of Anne Bingemann to establish better guidelines.

I think that both of those things could be done and could be done long before we pass the health care bill. And, I have no reservations at all about discussing this subject with Anne Bingemann when she comes up for confirmation. I feel certain that the administration would be receptive.

We could probably put the whole question of expedited procedures for rural hospitals into effect before we are able to pass the necessary laws.

I might say to you, Mr. Chairman, that the concern about mergers of rural hospitals being challenged is something of a bugaboo. There has only been one challenge to a rural hospital. So, it is not really a problem. But I am willing to be helpful in seeing to it that new guidelines are issued if that is desirable. I am also willing to see to it that there are expedited procedures for getting opinion letters, which would make it possible for the hospitals to move forward with their deals.

Senator ROCKEFELLER. Do rural hospitals in southwestern Ohio, which is an area much like West Virginia have a problem with wanting to come together and being unsure as to what to do?

Senator METZENBAUM. No. Not that we know of.

Senator ROCKEFELLER. Just one more question. In your testimony you referred to "Federal authorities have not challenged a single joint venture or buying arrangement among hospitals." What did you mean by "buying arrangement"?

Senator METZENBAUM. For example, take four rural hospitals in South Dakota located at different places that want to come together to buy a certain quantity of products at a discount from a manufacturer.

They could work out a group buying arrangement to do that.

I have no problem with that at all.

Senator ROCKEFELLER. Senator Durenberger?

Senator DURENBERGER. No questions, Mr. Chairman.

Senator ROCKEFELLER. Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

I must say that I have had deep concerns over the whole antitrust picture for many years. Perhaps Senator Metzenbaum is familiar with this situation that came up a couple of years ago. I am reading from a newspaper article. "Ford Motor Company will introduce the Mercury Villager Mini-Van on Tuesday with the hope of giving Mercury dealers a much needed way to attract families to their showroom.

The model built by Ford, but designed by Nissan, further raised the competitive stakes for the Chrysler Corporation."

The article goes about the arrangement Ford has with Nissan. The Ford spokesman said his company did not feel confident it could sell the output of an entire plant by itself, so a partnership made sense. But antitrust law precluded an American partner.

Now I do not know the details of this, and I am sure the Senator does not know either, but I have a feeling that in the United States, we are pledging an allegiance to a law which has had its time. Circumstances have changed and I am not sure that the field of antitrust enforcement has stayed abreast with the changing times.

I am sorry that we are not hearing the other witnesses prior to your testimony, Senator, because then we could ask you more intelligent questions. The information I have on this issue is to a great degree anecdotal, and, obviously, the situation in our State involves urban hospitals, not rural hospitals.

But I do not think that the problems are restricted to rural hospitals and I am not sure it is quite fair—and I do not say that in a challenging way—for you to indicate great sympathy for the problems of the rural hospitals, but the urban hospitals somehow are quite different.

I am not sure what prompts you to take that approach.

Senator METZENBAUM. Well, I was responding in part to both Senator Baucus and Senator Daschle, who had addressed themselves to the question of rural hospitals.

Let me say, Senator, that I am not a novice in the whole question of hospital operation. I served on two hospital boards before I came to the United States Senate. I was on the board of St. Vincents Charity Hospital and I was Treasurer of Mt. Sinai Hospital.

I understand the challenges and the problems of hospitals and I am sympathetic to them. As a matter of fact, there are some things that occur in the hospitals that are of great concern to me from a cost standpoint. That is the fact that in some hospitals there is a monopoly for certain specialists' services that causes costs to go up very, very substantially.

With respect to the whole area of competition, I do believe that, generally speaking, competition serves the free enterprise system well. I am proud of the fact that John Sherman, a Republican Senator, and my predecessor by many years, was the original author of the Sherman Antitrust law. But I think you and I would not really disagree that antitrust enforcement helps the free enterprise system.

Senator CHAFEE. No one is arguing against the Sherman Antitrust law. All I am saying is that it seems to me that what was

valid, addressed a tremendous problem in 1900 is worthy of review as we come into a worldwide globally competitive system.

Here is the situation. Do you see a difference between the need to obtain, or preserve, competition between two entities that are for-profit and the combination of two not-for-profit hospitals trying to reduce costs by merging? It seems to me there is a difference.

Senator METZENBAUM. I see some difference, Senator. But I do not see a total difference. I think it depends, to a great extent, upon the leadership and the operation of the hospitals. We have a nonprofit institution in our community of which we are very proud. It is Cleveland Clinic.

But do I think that they do everything perfectly? No. And there has been publicity to that affect. Do I think that their rates are extremely high? Yes. Am I certain that they should be lower? No. But I think that you cannot just take the position that a nonprofit hospital should be permitted to charge anything it wants and do anything it wants.

You have to look at the issue much more closely than that.

Senator CHAFEE. Well, Mr. Chairman, I note my time is up. But I also would point out, as Senator Metzenbaum, knows, not only is there a fear that comes with getting tangled in an antitrust problem, there is also the fear of the legal costs that are involved in trying to avoid it.

Senator METZENBAUM. That is the reason I suggested the expedited procedure.

Senator CHAFEE. And finally, as the Senator well knows, there are triple damages if you are guilty under the law. That is a powerful threat against entities that choose to merge or cooperate in some fashion when a lawyer comes in and says, oh, no, you cannot do this because of antitrust problems.

Senator METZENBAUM. That is the reason I suggested the expedited procedures and guidelines, so that you would not have to spend $100,000 or $200,000 on legal fees, but you could resolve it much less expensively.

Senator CHAFEE. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Senator, you have already addressed your sympathy with the rural concerns. Let me just briefly amplify my perception of their perception. It struck me very often when I visit with Montana hospital administrators in, say, Missoula, MT where there are two hospitals, or Great Falls where there are two hospitals, how much they dislike to engage in duplicative activities. Both have a major cardiac center, both have the best neonatology unit, for example. Both provide helicopters.

I agree a lot of the problem is the present construct and how we are all set up today with our present health care system.

Senator METZENBAUM. You should be able to contain that.

Senator BAUCUS. Let me just continue, Senator. They are very worried that when they start to share to reduce costs, to get efficiencies and reduce the burdens on their patients' bills, that they are not allowed to talk among each other.

It has gone so far that sometimes when I meet with Montana hospital people and doctors and nurses and so forth, they do not want to have the staffs of the same hospitals together. I ask about what the hospitals are doing. They say that antitrust problems are just in their way. That is the perception.

Now, you say the expedited guidelines and talking to the Attorney General for antitrust, Anne Bingemann, for example, that we will work out a solution. I do not know if that is enough. That still puts a burden in many cases, in my judgment, given our present health care system, on those hospital administrators who, I think—it is my judgment—are trying to do what is right. I mean, they are trying to lower costs.

They are not trying to get away with anything. They are really trying to lower costs. I think it is putting still too much of a burden on them to say, well, we will expedite guidelines so that you get an Attorney General's opinion saying that the proposed activity is not in violation of U.S. antitrust laws.

I believe you have to go further. As we did, for example, in the National Cooperative Research Act, I think it was 1984. We did not say that all joint ventures for research activities by countries violates antitrust law, but we did provide language making it easier to cooperate—and you may have wrote the bill for all I know.

Senator METZENBAUM. I did participate, indeed.

Senator BAUCUS. That there is language in that bill which clarifies that certain activities do not run afoul of the antitrust efforts.

So I would ask your reaction to not only expedited guidelines and so on and so forth, but also language similar to that which I have just referred to in that statute.

Senator METZENBAUM. I would be very willing to explore any language that the Senator might suggest or anyone else might suggest. My feet are not stuck in concrete. It is not my view that nothing can be touched. I recognize that there may be ways to do it, legislatively.

I just want to be certain that when we have a problem that we do not let the pendulum swing all the way the other way and open the door too wide.

I think that there are many in the American Hospital Association who now think that this is the time to go through the door and weaken our antitrust laws.

Senator BAUCUS. I appreciate that and I agree with you. I think some are using rural concerns as an excuse to go much too far. However it is my opinion that the guidelines alone are insufficient to address this particular concern.

Senator METZENBAUM. Let me suggest that the administrators come in and meet with the Justice Department and see whether or not they can work out the things that they want to do.

Senator BAUCUS. I will tell you why. These are people 2,000 miles away from Washington, DC. The specter of the Department of Justice is very, very burdensome. There is a fear factor. This perception, that they are going to get all tangled in all kinds of red tape and delays and letters and travel costs to come back and see and so on and so forth while they talk to the lawyers.

Lawyers tend to be very conservative on these matters and get the health professionals all worried and frightened, too. You know, probably to get a fee. I do not know.

Your solution, in my judgment, tends to put too much of an unnecessary burden on the administrators. I think that the law should be a little clearer so that they do not have to go through quite so many hoops, with either their attorneys or airplane flights or what all and what not, so they can go ahead and address their concerns.

Senator METZENBAUM. I think there might be a pretty simple procedure. If the Senator wants to bring the hospitals in, maybe one from the Justice Department could come over to meet with them. I would be very happy to have my staff work with you. I think the problem can be solved in short order.

Senator BAUCUS. I hope so.

Senator METZENBAUM. You rang the bell on that one.

Senator BAUCUS. Thank you.

Senator ROCKEFELLER. Senator Metzenbaum, thank you very much. It is usually the procedure in the Senate that when a Senator comes to give testimony, it is given and then the Senator leaves. You always seem to attract questions and opinions which I think you should be very pleased about.

In other words, I wish to say that I am pleased by what you had to say and the attitude with which you presented your testimony. I am really grateful for your coming.

Senator METZENBAUM. We want to work with you and the other members of your committee, not against you. We think that the whole issue of health care reform is so challenging that the more cooperation we can bring about, the better.

I believe that many compromises are going to have to be made in order to pass such legislation and I look forward to working with the Chairman and such other members of the committee that have an interest in this issue.

Thank you.

Senator ROCKEFELLER. Thank you very much, Senator Metzenbaum.

Senator CHAFEE. Mr. Chairman, I would just like to say one final thing, if I might. I appreciate Senator Metzenbaum's belief that there can be "expedited" procedures.

I am currently in a wrestling match with one branch of the government, one agency, and I have come away believing that it is very, very hard to move the Federal Government in any direction.

You may believe you can get expedited procedures, and if you can, three cheers. But in my dealings with the Federal Government, they are going to take their own sweet time and they are not cowed by any Senator or whoever it might be.

In this particular contest I am having, they are winning all the way.

Senator METZENBAUM. Well, Senator, you and I came to this body just about the same day, the same moment some years ago and I am not going to quarrel with what you just said. There is no doubt about it. With some agencies you can knock your head against a stone wall and the bureaucracy thinks they own the government. Some are more cooperative.

I am hopeful that the new Justice Department will be more cooperative. I think that under James Rill, there was a sense of cooperation and an open door policy. I think some of his predecessors did not have that same policy and were not particularly interested in seeing the laws work in the interests of the people of this country.

Senator ROCKEFELLER. Thank you, Senator Metzenbaum, very, very much.

Senator METZENBAUM. Thank you.

Senator ROCKEFELLER. Our second panel consists of Ellen S. Cooper, who is Assistant Attorney General, and Chief, Antitrust Division, State of Maryland, and Chair of the Health Care Working Group, National Association of Attorneys General; James Egan, Jr., who is Director of Litigation for the Bureau of Competition, the Federal Trade Commission; and Phillip Proger, who is a lawyer with Jones, Day, Reavis & Pogue in Washington, DC.

Mr. Proger, because you are going to give us a "big picture" look at the issue of antitrust, I would like to start with you. Your statements are all included in the record automatically. We will go ahead and use the 5-minutes clock. Why do we not start with you, sir?

STATEMENT OF PHILLIP A. PROGER, ESQ., JONES, DAY, REAVIS & POGUE, WASHINGTON, DC

Mr. PROGER. Thank you for inviting me. I am pleased to be here and pleased to address this very important issue. Listening to the opening remarks of Senator Metzenbaum and the subsequent discussion with him, if I may, in order to be more helpful, I think what I am going to do is digress from what I had prepared to talk about and address what you seem to be more interested in.

I do confess that it is a daunting task to respond to these issues in allotted 5 minutes. I will do my best. I am here, I think, because I am an individual who, as a lawyer and hospital trustee, has been involved in integrated delivery networks. As a matter of fact, I have represented hospitals and other providers in each of your States and I have represented them on these very issues.

I am also here because I believe that the antitrust laws rather than being a barrier to health care reform are actually an ally of reform. That is not to say there are not problems. That is not to say that in any enforcement regime there are not specific anecdotes that raise concern.

Certainly the American hospital industry has a right to have some concern. You should also know I for many years have been a hospital trustee myself.

We built up our hospital system pursuant to a national policy to have redundancy and inefficiency in exchange for convenience and service. Now changing demographics and increased costs requires us to rethink that policy and restructure our health care industry to eliminate redundancy and create efficiencies to reduce costs.

I will tell you as one who goes up against the Federal antitrust enforcement agencies that I have found them responsive to these issues. Behind the numbers that Senator Metzenbaum quotes to you today is the fact that the agencies are applying a rational policy to the need to integrate and create efficiencies. They are taking

into account the issues that you are concerned about and they are looking very carefully at these transactions. As pointed out by Senator Metzenbaum, very few hospital mergers have been challenged. Only those transactions that threatened consumer welfare have been challenged.

The paradigm that we must address is as follows: when you increase integration, through horizontal mergers, decrease consumer choice. Each of us has fewer choices and there is less competition. The trade off is that you get increased efficiencies. The issue that confronts the enforcement individuals and all of us is how can you be assured that those efficiencies will be transferred back to the consumer and not kept as profits by the merged entity.

That is what essentially I believe reform is all about. It is going to a health care market where we have large sophisticated purchasers interacting with integrated, efficient sellers to keep prices down and improve quality.

But in this system you have to have competition to ensure that it is the American public that gets the lower costs the higher quality and the better service. Competition ensures that the benefits of efficiencies created by mergers are not kept by sellers, that is providers, in the form of higher profits.

That is the role of competition and the antitrust laws are the watchdog of the game of competition.

On the issue of integrated networks as envisioned by health care reform, if you look at what is going on across the country, it is happening and it is happening rapidly. Minnesota and California, for example, are already there. In both those States, providers—hospitals and physicians—have created efficient, integrated delivery systems. Recent evidence suggests that competition among these networks is bringing down health care costs.

You have a lot of efficient, very able, very successful hospital systems led by very dedicated individuals. Even in rural areas you are seeing a lot of efficiency creating integration. But, we must have competition, and correspondingly antitrust, to ensure that the cost savings go back to consumers and are not retained by the sellers.

There is a perception problem. But the nature of laws are that people always have a perception problem as to whether they are violating the laws or not. Rural markets pose an interesting question. On one hand—I see the yellow light is on—they are actually less troublesome from an antitrust standpoint because in many instances the providers who want to work together, are not competing in the first place. Thus, there is absolutely no antitrust risk for them. If you have a rural hospital that wants a remote access to an EKG or an MRI, it does not require approval. The fact is that the antitrust agencies have never challenged such a joint venture, nor are they going to challenge it, because there is no affect on competition and no reduction in consumer choice.

If anything, there is an increase in consumer choice and there are efficiencies. There was a discussion with Senator Metzenbaum about MRI's. The reason why the antitrust agencies are not challenging MRI joint ventures is because most of them are being done quite lawfully under the antitrust laws. Where you have a situation that there is an expensive piece of equipment and neither hospital to the venture can afford it, then there will be the efficiencies

and there will be no reduction in competition since neither hospital alone would have acquired the MRI in the first place. Under the antitrust laws, there is nothing wrong with a joint venture like that.

If I may, could I just touch on the perception issue?

Senator ROCKEFELLER. Sure.

Mr. PROGER. That is a difficult issue. I am sympathetic. I see on FTC enforcement individual sitting in the audience who I know has commented that the agency has spent more time speaking to the health care industry than any other industry and yet there still seems to be uncertainty.

Antitrust law protects competition. What constitutes competition depends upon the facts and circumstances of each situation. Thus, by necessity, the antitrust laws do not lend themselves to simple, bright line tests. These are laws that impose an analytical discipline on how you determine whether a particular act or practice will adversely impact competition and reduce consumer welfare. They are not a set of laws that say you go from A to B to C. And that is good.

Your predecessors who passed these antitrust statutes are to be complimented on the flexibility they created.

The concern I have is if we go towards more precise safe harbor rules, we are going to fence in a lot of lawful conduct, which today are passing muster and are not being challenged.

If we draft safe harbor or other regulations, I think we are going to be over-inclusive. On the other hand, I am sympathetic to the concerns of hospitals in general and rural hospitals in particular.

I think the answer lies in continued education and guidelines that while they are not safe harbors create a general analytical framework, like the merger guidelines, on how these transactions are going to be analyzed.

I will not indulge your patience further except to say one final point. The modern era of antitrust enforcement in health care is very recent and it is not surprising that there has been this period of uncertainty.

I am very sympathetic to those providers who are in the marketplace that have had to live with it. But I do think that the courts and the enforcement agencies are now establishing a pretty clear track record that can provide guidance.

Thank you very much.

Senator ROCKEFELLER. Thank you, sir.

[The prepared statement of Mr. Proger appears in the appendix.]

Senator ROCKEFELLER. Mr. Egan, we welcome your testimony. And also, you might introduce the economist who is with you.

Mr. EGAN. Yes, sir. At the subcommittee's request, I am accompanied by Dr. James Langenfeld, who is the Director for Antitrust in the Bureau of Economists at the Federal Trade Commission.

Senator ROCKEFELLER. Welcome.

STATEMENT OF JAMES C. EGAN, JR., DIRECTOR FOR LITIGATION, BUREAU OF COMPETITION, FEDERAL TRADE COMMISSION, WASHINGTON, DC, ACCOMPANIED BY DR. JAMES LANGENFELD, ECONOMIST

Mr. EGAN. Like Mr. Proger, I will depart from my prepared 5 minutes since I find nothing to disagree with from what Senator Metzenbaum said; and, in fact, would simply emphasize some of his points. And, in fact, I find nothing to disagree on what Mr. Proger has just said. Although we have disagreed on occasion over the years in the context of specific cases.

I would emphasize that antitrust has an important role to play in any competition-based health care system, such as one using managed care. And, in fact, as Senator Metzenbaum pointed out, antitrust has made it possible for managed care to develop in the United States over the years.

He noted some of the cases in which the FTC has brought boycott cases against hospitals and doctors which attempted to keep managed care out of particular markets. He also mentioned the AMA's ethical position on managed care, which the FTC overturned in their case against the AMA that commenced in 1975.

The second point that I would emphasize is that, in fact, any free enterprise system, any competition based system simply cannot exist without antitrust. The whole concept of managed care is that managed care plans negotiate with providers such as hospitals in order to obtain lower costs, lower prices, and the best quality at those prices.

Well, I think it is just common sense, confirmed by economic theory and history that you cannot negotiate with a monopolist. You accept a monopoly price, period.

And the same thing is true when you have a limited number of suppliers in the market and those suppliers are inclined to price on a joint basis rather than a competitive basis.

The third point that I would make is that antitrust is not an obstacle and I would just affirm what has been said here already. We have never attacked—the FTC has never attacked, to my knowledge the Justice Department has never attacked, in fact, to my knowledge there has been no antitrust case even by private parties against any joint activity by hospitals, joint sharing activities, such as the sharing of an MRI.

The sharing of a helicopter is the, perhaps, extreme example that was mentioned earlier by Senator Baucus. I have heard that example on a number of occasions, as I have about the MRI's.

Not only have we never investigated or attacked the sharing of helicopters, I cannot imagine a situation in which we would do so. The efficiencies from sharing helicopters just jump out at you.

Therefore, I think that the record is, as it is on merger enforcement, that we simply are not an obstacle, have not been an obstacle. And given modern analytical modes of antitrust, are not likely to be an obstacle in the future.

I would like to just note——

Senator CHAFEE. Well, I just want to say something on this if I might.

Senator ROCKEFELLER. This will not subtract from your time, sir.

Mr. EGAN. Thank you.

Senator CHAFEE. It all sounds so lovely, Mr. Egan. But just try to get an answer out of your outfit. And I know. I have been involved in one particular matter for 4 years, and we have yet to get an answer yes or no from the FTC.

So when you just breeze through this and say, "We do not present any obstacles, we are going to do everything we can for helicopters, do not worry," it does not work that way when one is dealing with a government agency, and especially with yours.

Mr. EGAN. Well, I am a litigator by background.

Senator ROCKEFELLER. He is in a good mood today. [Laughter.]

Mr. EGAN. I am a litigator by background. When someone puts forward a general objection like that, I generally tend to ask for the specifics. But I understand that the matter that you are talking about may be a matter that is in litigation.

Senator CHAFEE. Oh, it is shrouded in secrecy so that no one can tell me anything.

Mr. EGAN. But just let me say, I am not up here to say that the FTC does not challenge mergers. I am not up here to say that the FTC does not challenge anti-competitive practices. That is our business.

We make people unhappy when we do that. But——

Senator CHAFEE. No, that is not the complaint. The complaint is, you do not give an answer.

Mr. EGAN. Well, let me speak to that.

Senator CHAFEE. When you say so blithely "We do not interfere in these matters and it is perfectly all right by us," that may be, but just try to get an answer when you are dealing with these government departments.

Your agency holds the all time championship.

Mr. EGAN. Well, let me respond to that specifically. We have in place at the FTC, and certainly we would be willing to consider any modification which would make it more expeditious, but we have in place a system whereby people can get advice about things like sharing helicopters, for example.

The system really has three prongs to it. One, people all the time call our health care office and ask for general advice about general things that they would like to engage in. And if they want, they can just place a telephone call to our health care office, which is headed by Mark Horoschak, and ask a question of that sort.

Our second prong is a staff advisory opinion, which is relatively speedy and the parties can write in and ask advice from the staff of the Federal Trade Commission and the staff will render advice.

Again, on something like sharing a helicopter, sharing an MRI, sharing laboratory services, sharing a laundry service, those types of things are things that they can get advice on very, very quickly.

The third prong is to get a formal Federal Trade Commission advisory opinion and that will take a little more time. But those opinions are reserved for instances in which there is a very, very difficult question, a new antitrust issue that the FTC should pass on.

But for the most part, there is a procedure already in place to get answers to these kinds of questions.

Senator ROCKEFELLER. Mr. Eagan, why don't you wind up your presentation.

Mr. EGAN. Yes, I will wind up just by repeating what Mr. Proger said. We have, as a matter of fact, attempted. This perception problem is very hard to get a hold of. I am not sure why it continues. We are concerned about it. We do go out and we do give more speeches in the health care area than any other area and we try to put the word out that people can share helicopters, people can share MRI's under normal circumstances if they do not abuse that procedure, where they are efficiency enhancing.

So far, I cannot say why that has not worked and certainly we would be open to proposals to make our process more efficient at getting the word out.

Thank you.

Senator ROCKEFELLER. Thank you very much, sir.

[The prepared statement of Mr. Egan appears in the appendix.]

Senator ROCKEFELLER. And now, Ms. Cooper.

STATEMENT OF ELLEN S. COOPER, ASSISTANT ATTORNEY GENERAL, AND CHIEF, ANTITRUST DIVISION, STATE OF MARYLAND, AND CHAIR, HEALTH CARE WORKING GROUP, NATIONAL ASSOCIATION OF ATTORNEYS GENERAL, BALTIMORE, MD

Ms. COOPER. Mr. Chairman, speaking for myself as a State antitrust enforcer I believe strongly in competition. I am not going to go through some of the details about why I am in general agreement with the remarks that have preceded mine. But I do have a slightly different perspective because I am a State antitrust enforcer rather than a Federal antitrust enforcer.

I believe that antitrust laws can have a positive and necessary impact in the context of managed competition. And State antitrust enforcers have already prosecuted practices that could interfere with this type of health care reform.

For example, 34 States, including Maryland, sued a pharmaceutical company for requiring that patients using its medication receive blood monitoring services from one designated source. In 1992, in a $20 million settlement, applicable to all 50 States, this anti-competitive practice was enjoined. This practice, if unchecked, would have prevented all provider groups in a managed competition setting from even offering lower cost blood monitoring services to buyer groups.

State Attorneys General have been willing to permit collaborative ventures necessary to enhance medical services, providing that checks and balances are established. For example, the Attorney General of Minnesota recently entered into a consent agreement that provisionally permitted a hospital merger to proceed in the St. Paul, Minneapolis area. That settlement provided that the Commissioner of Health could require dissolution if the merger did not result, in fact, in lower health care costs or greater access to quality care than a competitive market could provide.

I cannot claim that the antitrust laws will permit every collaboration or merger or that it should. And for this reason health care providers argue that they need an exemption.

But I believe that it is State government, and not the private sector, that should determine whether and when the antitrust laws ought to stand aside to permit that type of collaboration. After all,

it is State governments that are responsible for the welfare of their citizens and it is State officials who are accountable to these same citizens.

Current antitrust laws provide the States with a long established mechanism for superseding the antitrust laws when State officials deem it necessary and that mechanism is called the State action immunity doctrine. Under this doctrine Federal laws allow States to exempt particular conduct from antitrust scrutiny by substituting regulation for competition.

Recent legislative initiatives in the States have demonstrated that the States are increasingly willing to undertake the hard work of determining if their citizens' needs for health care alternatives ought to supersede the role of competition in our economic system.

Now, in my view as an antitrust enforcer, I believe many of these efforts have been overbroad. But I will discuss two of the better models.

Maine's recent legislation permits a hospital to negotiate and enter into cooperative agreements with other hospitals in the State if the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that may result from the agreements. The Maine Attorney General is responsible for monitoring the effects on competition of such cooperative agreements. Montana has recently enacted legislation that is quite similar to Maine's.

Washington has also recently, I believe within the past week, enacted legislation that provides State action immunity for activities in the health care industry taken in furtherance of its act. A list of exceptions to the general rule of exemption includes certain per se violations of State and Federal law, including, for example, price fixing.

Acting with other agencies, the Washington Attorney General must periodically analyze the market power of certified health plans and determine whether a more competitive alternative is practical. The benefits of collaboration must continue to outweigh any disadvantages resulting from a reduction in competition.

In conclusion, as a State antitrust enforcer, I strongly believe that the antitrust laws should have an important place in an evolving American health care system. But I also believe that the States carry the primary responsibility for reconciling differences between antitrust policy and the needs of our new health care system and determining what those needs are.

The States have proven their capability to handle this problem by enacting legislation and also through the sensitive and public spirited way in which State Attorneys General have enforced the antitrust laws as they apply to our present health care system.

Thank you.

[The prepared statement of Ms. Cooper appears in the appendix.]

Senator ROCKEFELLER. Thank you, Ms. Cooper. Ms. Cooper, let me start with a couple questions for you. State action immunity is one way for an organization to be protected from antitrust enforcement. What is a current example of that State action immunity as it relates to health care?

Ms. COOPER. Well, actually, my own State of Maryland provides a very clear example. My State has an all payer system for hos-

pitals and the State itself sets all hospital rates. It is a pure regulation model. And under that system, not only are all hospital mergers exempted from the State antitrust law, but also, I believe, through the State action doctrine, so are all hospital mergers and collaborations to purchase major medical equipment exempted from the Federal antitrust laws.

That is because the State legislature has clearly articulated an intent to regulate in this area and the States closely supervises the activity of private actors in this field.

Senator ROCKEFELLER. Which is what I wanted you to say, because, as you know, one could really say that the Maryland hospital system is a very good example of price fixing. So that if it is done by the legislature you are protected by State action immunity.

What would happen, for example, if all the hospitals in major metropolitan regions throughout this country set prices outside of their State governments, in a sense sort of volunteering to create their own all payers system? What would be the affect of that?

Ms. COOPER. That would be a clear violation of the antitrust laws. There is no authority for them to do that under the law and there is no supervision. In Maryland there is an independent State agency that reviews prices that compares rising prices with inflation and various other factors and that does the rate setting, taking into account the interests of the citizens of the State.

And, of course, the rate setting is done by officials who are publicly accountable.

Senator ROCKEFELLER. Well, in that Maryland appears to be successful, would other regions wishing to do the same thing in order to avoid antitrust have to go through their State government? Is it just going through your State government and saying, we have something called State supervision? Is that a way not to worry about antitrust legislation?

Ms. COOPER. Well, State action would exempt activity of individuals if they could convince their State government that what they were attempting to do would be beneficial for citizens of the State. But it also does require quite close supervision by the State, which, of course, carries its own costs.

Senator ROCKEFELLER. Mr. Egan, when you've referred to sharing MRI's, you said it would be okay for hospitals to discuss joint ventures as long as they do not abuse it. What do you mean by that?

Mr. EGAN. Well, I mean by that, Senator Rockefeller, the situations where we see MRI sharing, there is no real concern because, number one, normally there is not a concern about competition to begin with. There are other options in the community for people who need MRI services.

Number two, there are efficiencies normally in two hospitals sharing an MRI. Perhaps two hospitals cannot each support a single MRI, but together they can support a single MRI. But suppose, for example, that someone monopolized the MRI's in New York City. Well, obviously, there is no need to do that. There is no efficiency from that. And there would be monopoly concerns about that.

But we do not see that situation. That is not the situation we see. And that is why we would never attack one of these joint ven-

tures, because the situation we see is not anti-competitive and is for the most part efficiency enhancing.

I am just saying that there could be scenarios under which someone set out to monopolize a given market and was not concerned about efficiency.

Senator ROCKEFELLER. It is ironic when one is trying to define competition, that if we go to phased-in community rating for the insurance industry, the effect will be to diminish competition since there will be a number of insurance companies that will go out of business.

But one could make the argument that the only way to get real competition is to reduce the number of those competing in the insurance industry eliminating those who are going for the niche markets and they have to manage risk as opposed to avoiding risk, which is what insurance companies now do.

So that by setting out guidelines you force competition by reducing competition through health insurance reform. Is that not correct?

Mr. EGAN. Well, the market does that all the time. The market decides——

Senator ROCKEFELLER. The market does a terrible job of that.

Mr. EGAN. Well, in some industries it does a less good job than in others. But——

Senator ROCKEFELLER. Well, I am talking about the insurance industry. Is that not an example of where competition has been antithetical to the interest of the consumer?

Mr. EGAN. Well, all I am suggesting is that antitrust is not standing in the way of that. Antitrust, if there are, for example 30 providers in a given market, whether it is insurance or anything else, and two of those providers or three of those providers or four of those providers get together, presumably there is no lessening of competition under the antitrust laws because there is a sufficient amount of competition remaining.

So antitrust just does not enter into the picture on those situations.

Senator ROCKEFELLER. You may be right. It just occurred me as something that was interesting.

And, frankly, I share that view, that for rural hospitals their administrator, the Board of Trustees, it is very hard to get them to come to Washington and sit down. They are intimidated by the process.

So it is my understanding that you have tried to improve your efforts to provide clarification to health care providers on antitrust issues.

Later today we are going to hear from Steve Wetzell on behalf of the Business Health Care Action Group. He will make a very good point. He will say, "Business persons are not antitrust experts. We have learned that antitrust law does not produce the kind of short, simple and unambiguous conclusions that business people need to act decisively. Business people need clearer signals."

Today's hearing exemplifies the need for FTC and the Department of Justice to do much more clarification. That is this whole problem. In other words, it sounds good, as Senator Chafee said,

but it just does not work. It intimidates because of human nature, because of distance, as Senator Baucus said, and that is a reality.

And Senator Metzenbaum said, come bring your people and we will talk and reason together. But people need direction. Business needs predictability. What are you doing to clarify? How far do these steps go in clarifying antitrust with respect to health care?

Mr. EGAN. Well, I can only repeat that we do spend a fair percentage of our resources on outreach, going out and talking to members of the health care community about what our policies are on antitrust. I, frankly, do not understand why we have not been more successful in getting the message out.

All I can say is that we are open to suggestions and that we will do what we can. But I just know——

Senator ROCKEFELLER. But can I say that there is a law regarding the earned income tax credit that people are meant to know about it. And, in fact, there are about 2 to 3 million American families who are eligible for earned income tax credit that simply do not know about it.

The IRS can stand there and say, look, we have been trying and we do not understand why it has not worked. But the fact that it has not worked has had devastating effects on working families trying to get out of poverty. The government says on the one hand we want to help you get out of poverty and then the bureaucracy says we are trying, but 3 million of you do not know about it.

Do you understand my point? I am not trying to be hostile.

Mr. EGAN. Yes, I certainly do. Can I just note for you, however, that in 1989 the American Hospital Association put out a fairly thick "Hospital Mergers: An Executive's Guide Through the Antitrust Thicket." On page 20 of that, for example, the American Hospital Association says, "The general analytical framework for analyzing the antitrust ramifications of hospital mergers is well established."

And then it goes through to give a summary of how you analyze mergers. It tells the executives that.

Senator ROCKEFELLER. And I will expect the AMA to respond to that, too.

Mr. EGAN. And let me quote another short passage earlier, at page 9, "Under the FTC's advisory opinion procedure, the parties can seek the advice of either the commission or its staff about the proposed transaction. This often provides a relatively clear signal as to whether the Commission would challenge it if the parties move forward."

As I said earlier, we have less formal procedure where hospital executives can call, or their lawyers can call, and ask advice and we give advice on an informal basis over the phone. As I said, if it concerns something easy, a question like helicopters, we will give that advice over the phone, or we may suggest that they write a letter and then we respond in writing or we may suggest that it requires something more formal from the Commission, which means that it would be a more significant antitrust question.

Senator ROCKEFELLER. That is the end of my time. I will want the AMA to respond to that.

Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, I need to start off by saying I know nothing about antitrust law and I know just a little about, it is all anecdotal, as I illustrated in my opening statement, what goes on in markets.

But if I understand what we are talking about here, we are dealing with the role of consumer choice in the market. We are dealing with a system in which consumers cannot make choices because they do not have adequate information. Consumers are insulated from many factors by the indemnity system that they need to know more about. So somebody has to come in there and help make sure that prices are not going up and quality is not going down by mergers and things like that.

Now in this new system, or even in the old system before I forget on a point somebody was talking about in the rural areas, the doctors make the decisions in this system, not the people. So just because doctors cut a deal with a hospital in a rural area does not mean it is automatically not a problem.

Because a little group of doctors cuts a deal with one hospital, the other hospitals that those doctors might cut deals with go blah, blah, blah. I mean they ain't no more.

So I would just add that to whatever one of you said about rural areas rarely is that a problem, rarely do we question it. I would suggest you need to be questioning some of those and you need to get at it quickly and you need to decide it appropriately.

I also would acknowledge, as I hope I said earlier, that in my State it was not the FTC or it is not the Department of Justice challenging mergers. It is the Attorney General and he is all over, because there is so much going on and nobody really understands it, as I am illustrating by my comments.

Now, we are looking to this new managed competition environment. The basic question between Republicans and Democrats is going to be who is doing the managing. That gets to the difference between a market, which needs to have some of this consumer choice protected and enhanced, and the State immunity doctrine where the State Legislature or somebody like that is making all these decisions like they do in Maryland about what you ought to pay and what you get for it and all the rest of that sort of thing.

I have a little piece that is appearing, hopefully one of these days, in "Health Affairs" that says, the comparison between the results in Maryland and the results in Minnesota where the cost comparisons are roughly the same does not tell you anything because we have not really followed up competition in Minnesota.

And if we ever had real competition in Minnesota where everybody came to the Mayo Clinic from all over the country because it is the cheapest and best place to get your health care, we would leave Maryland behind—way behind.

Because Maryland's government run system is only going to get so much productivity. And unless you facilitate a system in which people actually get rewarded for being the best at what they do and giving you the greatest value, it is not going to work.

So I am trying to ask each of you a little bit about what you know about managed competition, what you know about health alliances and these oncoming purchasing groups which are designed

to enhance consumer choice by presenting consumers with a choice of accountable health plans.

These accountable health plans, as I understand it, are part insurance company—and hopefully they do not fall under McCarran-Ferguson anymore—and in part provider networks. The purpose of the accountable health plan and the competition between the accountable health plans is to increase the amount of real consumer choice.

So that consumers every year, instead of just taking the plan their employer hands them, sending the bills to the insurance company, getting them paid, the consumer is actually sitting there and comparing services on the basis of their past experience and the experience other people have been having and what the accountable health plan tells them every year they have done to improve the quality of service in their particular network.

They are actually sitting there getting smarter and smarter every year about what is a good service. So they are making these choices between the health plans.

There is another thing to add. We all agree that we are going to have a basic benefit package which each of these plans will have a set of services so that you can more readily compare each of these plans. That is to facilitate consumer choice, too.

My question is, looking at it from the standpoint of ensuring that we do not have interference with price, quality and those kinds of things in this system, where should the antitrust sensitivity be? It seems to me it ought to be at the accountable health plan level, rather than at the doctor/hospital traditional level.

Maybe we will start with Mr. Proger and you can help me understand it.

Mr. PROGER. I certainly agree. I think that the key concern we have here is to ensure that we have one of two systems. We can either have the market place make the choices and antitrust be the referee or we can have government regulation.

We as a society have never considered letting sellers make that decision. The reason is because we think that the best value for the consumer occurs when someone other than the seller is making that decision.

When you talk about these various collaborative arrangements, the key is, again, how are you going to ensure that the efficiencies get passed back to the consumers. That is what this is all about.

If you have a collaborative arrangement that puts all the providers of a given service in a marketplace together, then what you are likely to have is higher prices and lower quality. That has been proven time after time.

The goal of the antitrust laws are the same as the goal of health care reform, it is to ensure that those efficiencies get passed back to the consumer. How do they do so? By ensuring that there are enough other providers left in the marketplace that they compete with each other.

I would like to make one comment on the issue of the clarity. I agree there is a perception problem. But, frankly, as an antitrust lawyer and one who does this every day, I would like to believe it is rocket science, but it is not. It is not that hard. It is not that unclear.

The rules have been set forth for many, many years. They are well established in this country. All American businesses are subject to the antitrust laws and they live with them fairly well.

Ninety-nine percent of what goes on in health care every day has no antitrust problems. I, too, am frustrated by the issue of the perception that there is a lack of clarity. But it is clear. It is clear that you can engage in collaboration, mergers or joint ventures if you integrate, if there are still other competitors left in the marketplace to ensure that your efficiencies get passed back to the consumer.

If you want to allow all sellers in the health care marketplace to jointly negotiate, history teaches us that prices will increase and quality will decline. But we as a country have a national policy called the antitrust laws that competition ensures the best for consumers. For competition is democratic. Each of us votes every day when we choose which providers we utilize. Absent competition or rate regulation there is no way to ensure that the efficiencies get passed back to the consumer.

Senator ROCKEFELLER. But that is exactly what is probably going to happen in these alliances. I mean, everybody is going to be in there together.

Mr. PROGER. Well, the "issue then will be that you are going to need to have multiple AHP's so that they compete.

Mr. Chairman, Mr. Egan made a very important point, if what we end up with in any given market is just one accountable health plan and correspondingly one group of providers, they have no incentive to be efficient. Competition creates that incentive and it does so more effectively than regulation.

On this point, I want to provide the committee with a little bit of factual information. I am a native Marylander. My father worked for the Federal Government and I grew up here. So I am quite proud of this State. But I have done a lot of work in Hennepin County in Minnesota.

The Federal Health Care Financing Administration, that is HCFA, pay's HMO's an average adjusted per capita amount. HCFA data show that Minnesota's competition model to control health care costs outperformed Maryland's regulated model. Between 1990 and 1993 under Maryland's regulated regime costs went up 30.2 percent in Baltimore County and 26.3 percent in Baltimore City for an average rate of $510 in the county and $424 in the city.

In Hennepin County, Minnesota the increase during the same period of time was less than half, 12.8 percent and HCFA pays $353 per adjusted per person.

Senator DURENBERGER. That is in Minnesota for those that are not familiar with it.

Mr. PROGER. Yes. For average adjusted per capita amount. So competition in Minnesota did a better job of controlling costs than regulation did in Maryland. The job of the antitrust laws is to protect that competition.

Senator ROCKEFELLER. Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

I would like to pose a question to you, Mr. Proger, and you, Mr. Egan. I am quoting from the testimony of Mr. Pawlowski who is going to follow you on the next panel. Let me read you this.

Mr. Pawlowski describes that he is from the Bluefield Regional Medical Center in West Virginia. It is a nonprofit community-owned facility and provides a continuum of care.

"Like many communities throughout the country, the Bluefield area has more than one hospital. We have three facilities—two not-for-profit and one for-profit institution."

Then Mr. Pawlowski describes how he was on a study commission appointed by the government to review the joining together of medical facilities throughout the State.

"In light of my strong views on collaboration, the Bluefield Regional Medical Center and community leaders; which include several physicians, began preliminary discussions with another nonprofit community hospital in the area. Unfortunately, these discussions came to a screeching halt when the for-profit hospital in the area threatened to take legal action if the two hospitals continued what they said 'violated the antitrust laws.'

"In addition, my attorney has advised me that further discussions with other health care providers could put both me and my hospital at legal risk. Based upon that, my administrative staff and board members contend that at this time the risks appear to outweigh the advantages."

Now, Mr. Proger, what is the matter, did Mr. Pawlowski just have the wrong lawyer or he should call Mr. Egan?

Mr. PROGER. Well, I am not going to be as bold to say he had the wrong lawyer. I would point out two things. One, I think there are instances such as you described, Senator, and I think they happen every day. I think there are a greater number of instances where those transactions are going forward. I brought some articles with me to give to the staff from Modern Health Care and Business Week that talk about that.

Two, unless we are prepared to have a system that has either no antitrust as the referee of the game of competition or no regulation you are not going to avoid that cost. A regulated system also has costs. Often greater than the costs associated with antitrust. With a certificate of need or other regulation, there must be due process. That for-profit hospital could have engaged in the same threats and caused the same costs by their threats.

They may have blocked the transaction through an administrative proceeding in the certificate of need process.

Senator CHAFEE. By the way, I will just give you another fact Mr. Pawlowski had in his testimony. He says, "all three institutions have spent millions of dollars securing expensive, duplicate capital equipment. Two major hospitals in the area are actively recruiting OB/GYN physicians while each having 50 percent occupancy in this area."

So it seems to me he had a pretty strong case for collaboration, but the antitrust bugaboo scared them off.

Mr. PROGER. That they spent a lot of money securing expensive duplicative equipment is not the fault of the antitrust laws. The antitrust laws do not force them to do that. There are many reasons why facilities may choose to purchase equipment on an individual basis that have nothing to do with being concerned about being thwarted by the antitrust laws.

Senator CHAFEE. What do you say, Mr. Egan?

Mr. EGAN. Well, I do not know the——

Senator CHAFEE. Obviously, you do not know the complete details and I recognize that.

Mr. EGAN. Yes.

Senator CHAFEE. Nor do I. I just read from Mr. Pawlowski's testimony that he is going to come forward and present. But the point I am making is, or the point we have been trying to make, is that it is all well and good to say, do not worry about this stuff, just call Mr. Egan and he will talk to you.

These are people out in the real word who are being scared by the threat of antitrust actions and over it all looms triple damages.

Mr. EGAN. Well, I do not know of a single instance—perhaps I am wrong on this—I do not know of a single instance in which a hospital or any firm has been sued for treble damages on the basis of a merger. So I do not give too much credibility to that concern to tell you the truth.

Senator CHAFEE. Well, there is enough—Mr. Pawlowski says, "it put both me"—him, personally, I assume, "it put both me and my hospital at legal risk."

Mr. EGAN. Well, does it say whether he did inquire of the FTC or the Justice Department what——

Senator CHAFEE. It does not say that. It says, "Based upon that my administrative . . ."—his attorney so advised him, "my administrative staff and board members contend that this time the risk appeared to outweigh the advantages."

Mr. EGAN. Well, I cannot give a very good answer, I am afraid, simply because I do not know the details. I cannot say for sure that it does not pose competitive problems, first of all. There are not enough details from what you have said.

But assuming that it does not, it seems to me that if his lawyers believed it did not, but just were giving way to the threats of this third hospital, I would question whether that was a wise decision and question why they did not at least—if he had a lawyer, which apparently he did—why he did not pose the question to the FTC or the Justice Department.

Senator ROCKEFELLER. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Egan, you said you really do not understand why there is a perception problem. Think a little bit more about that. Why? Why do you think there is a perception problem? What is your honest, gut assessment?

Mr. EGAN. Well, if you want my honest gut assessment, I think that——

Senator BAUCUS. That is what I am asking for.

Mr. EGAN. I think that the antitrust laws are being used somewhat as an excuse by some hospitals.

Senator BAUCUS. I am talking about the rural hospitals. I am talking about—this is just based on my experience—smaller hospitals where there are say two hospitals, only two hospitals, in a city and I am thinking cities with a population of—one of the largest cities in my State is about 90,000; another city with two hospitals, oh, there is about 50,000 people in the area, whole service area—now why are they so intimidated and so nervous?

Mr. EGAN. If you could give me a specific. Are we talking about sharing an MRI?

Senator BAUCUS. We are talking about sharing either an MRI or allocating services, like one is going to be the cardiovascular center, another is going to be the OB/GYN center and so forth.

Mr. EGAN. That presents much more difficult questions, the allocation of specialties, because there does not seem to be on its face, there does not seem to be an efficiency reason why there has to be an agreement to do that.

Senator BAUCUS. They are not worried about an agreement. They just do not want to be sued.

Mr. EGAN. Well, I am saying, they will not be sued if they do not reach an agreement on that issue. If they just decide on their own that they will not——

Senator BAUCUS. An informal understanding. It just happens that way.

Mr. EGAN. I mean, if it truly just happens that way, then there is no antitrust problem. If there is an agreement, whether it is implicit—whether it is in a smoke-filled room or not—there may be a problem and we would have to look at it.

The question would be: Is there some efficiency to be gained by an agreement not to compete in certain areas?

Senator BAUCUS. Let us say there is, there is a significant efficiency.

Mr. EGAN. Well——

Senator BAUCUS. But they still worry about this Department of Justice or the Federal Trade Commission inquiry.

Mr. EGAN. I can only say two things. I think the allocation of services is a much more difficult area to analyze. I do not think the efficiencies leap out at you there.

Senator BAUCUS. Well, assuming there are definite efficiencies.

Mr. EGAN. Well, why can they not do that on their own? Why do they need an agreement to do that?

Senator BAUCUS. They feel the bills people are better served if there is allocation. That is just their——

Mr. EGAN. But they can make that decision on their own.

Senator BAUCUS. You know, it is legitimate, it is open, anybody who wants to attend can. But they just decide they are going through the bills and the operations and that is what they think.

Mr. EGAN. Yes. But they can make that decision unilaterally and they only run afoul of the antitrust laws if they get together and agree not to compete.

Senator BAUCUS. If they know they agree, it is not made unilaterally.

Mr. EGAN. Well, that is what I am saying.

Senator BAUCUS. But there are efficiencies.

Mr. EGAN. Well, but that is where—the key to efficiency analysis under the antitrust laws is it can only be achieved through this joint activity of some sort. If it can be achieved without the joint activity——

Senator BAUCUS. I think your answers are indicating why they are so fearful. I think you have answered your own question.

Mr. EGAN. No, let me——

Senator BAUCUS. I am sorry, sir, but I will be honest with you. I am getting the sense from your answers that you are—and you probably should be—a pretty tough enforcer. And you are asking an awful lot of questions as a tough enforcer should.

And because these resolutions are determined so much on the facts and circumstances of the case, because they are very complex, I think the same of the new application of the State action doctrine.

For example, Dr. Cooper stated that State action is okay so long as the State closely monitors to be sure there is no antitrust violation. I understand that and that makes good sense.

You referred to the State of Montana passing a statute. Yes, that is true, just about a week ago. And it will not go into effect, probably full effect, for a couple of years. You know, my sense is that if States keep going down this road that that, too, is going to be a very evolving area and States are not going to know—health care providers are not going to know how far State action really goes.

I just firmly believe, frankly, listening to your answers, that some kind of statutory provision is necessary to help deal with this perception problem.

I am assuming that nobody here is trying to gouge people. I am sure there are gougers. I am sure there are price fixers. I am sure there are people who are trying to use this analysis of the road we are going down as an excuse. That probably happens.

But I am also saying there is a very legitimate problem in smaller communities that I think has to be addressed.

For example, let's talk to these DOJ letters. As I understand the Department of Justice letter states that, "we do not intend to sue you at this time." Well, gee, that could give someone a lot of comfort. I do not know. It is your letter. What do your letters say when you send a letter out? Do they have similar language or does this say, this is absolutely right and we are not going to ever sue you if you continue to do this?

Mr. EGAN. Well, we have a similar caveat in the letter. But the fact of the matter is, I do not know of a single instance in the case of the Federal Trade Commission or the case of the Justice Department in which we have given formal advice and then sued somebody. It is a——

Senator BAUCUS. I understand that. I appreciate that. But still, I see those words. These are people who really mean well. They are not sophisticated antitrust lawyers. Frankly, I do not know if the State of Montana has anybody that specializes in antitrust law. There probably is not anybody.

But they see a language like that and they say, oh, my gosh, you know, what does this mean. You know, I cannot do this. It is just very, very intimidating. And I think that is part of the perception problem.

Mr. EGAN. Could I quote again? I have two points if I could respond. Two points. A quote again from the AMA's own document where they say that the FTC's advisory opinion provides, "a relatively clear signal." AHA, I am sorry.

The other thing, the other point——

Senator BAUCUS. That is on mergers.

Mr. EGAN. Yes, sir.

Senator BAUCUS. I asked an allocation question. I am not talking about mergers. We are not a big State. We are not really talking about hospital mergers. That is not the issue. We are talking about allocation issues.

Mr. EGAN. Yes. I think the logic of it applies to all types of collaborations.

And I think the second point I would like to make is, when you talk about mergers and collaborations that the proof is in the pudding. I understand that the AHA recently conducted a survey and discovered that there are over 300 hospital collaborations in the United States right now.

There was a story in Modern Health Care, a health care publication, on October 12, 1992, and the title of the story was "Mergers Thrive Despite Wailing About Adversity." And there is a picture of a little boy crying wolf on the cover and underneath it says "mergers and collaborations." And the thrust of the story is that there are all sorts of collaborations going on in the health care industry and that antitrust has not stood as an obstacle to any of those.

Senator BAUCUS. I am just going to tell you, you are not giving very much comfort.

Mr. EGAN. I am trying the best I can.

Senator BAUCUS. You are not.

Senator ROCKEFELLER. Mr. Egan, I want to ask just one final question. It follows what Senator Baucus was asking about.

There is growing support in my own State for more systematic coordination of health care services. We have a couple of big cities and everything else is rural. Declining hospital occupancy rates have resulted in under-used capacity and communities need to prioritize their health care needs intelligently.

One example might be making sure prenatal care and obstetrical care is available in that community, but perhaps maybe not heart surgery. Now some of the planning and the coordination of services will inevitably involve health care providers and community leaders sitting together in the same room to discuss basic issues like these.

Later today the American Hospital Association will testify about an incident in Wichita, Kansas in which the local Chamber of Commerce, concerned about the unnecessary duplication of services in the area, wanted area hospitals "to meet and collectively allocate services, equipment and facilities among themselves."

The Chamber "inquired as to whether the involvement of organizations with wide community support could reduce antitrust risk" just by the nature of there being wide support.

According to AHA's testimony, the FTC responded negatively to their inquiry. Could you comment on that case? And since Wichita is not the same as Bluefield, West Virginia which was discussed earlier, does urban or rural location make a difference in FTC's determination on what is appropriate and what is not?

Mr. EGAN. Well, let me start with the last point. It makes a difference in the sense that it provides a different context for the activity, the collaboration, that is being proposed. In rural areas quite frequently the population may not be sufficient, for example, to support more than one MRI in a given community.

If that is the case, then a joint activity among hospitals in that community, even though it is the only MRI in that facility, it may actually be pro-competitive in the sense there would be no MRI but for that collaboration.

So the rural nature of the area does impact on the analysis in that sense and in other ways. The question of allocation of services, I think, also needs a context. When competitors get together and allocate services, that in effect really is no different than outright price fixing.

If one competitor says, I will make all the small cars, you make all the big cars and you make all the trucks, well then you are really dealing with three monopolists.

So the concern about allocation of services from an antitrust perspective is similar to the concern we would have about merger to a monopoly, and about price fixing. It is different than what we normally see when we are talking about sharing MRI's, when we are talking about sharing helicopters and things like that.

Now, if, in fact, there is only room in the community for one heart program, hospitals can get together and legally put together a single heart program for the community.

Senator ROCKEFELLER. Why can they do that legally?

Mr. EGAN. Because there is only room for one in the community and there is not going to be——

Senator ROCKEFELLER. And who determines that?

Mr. EGAN. Well, I mean, we look at that question as to whether or not it is a pro-competitive joint venture in the sense that it is bringing something to the community, bringing something to the marketplace that otherwise would not be brought to the marketplace.

But if you have——

Senator ROCKEFELLER. Let me just interrupt again and you can have all the time you need.

Mr. EGAN. Yes, sir.

Senator ROCKEFELLER. We are talking about one out of every $7 spent in the United States of America on anything is spent on health care now, more to be spent soon. That implies a level of sophistication concerning data, which you may very well have with Mr. Langenfeld.

But, witness the White House task force, with over 500 people coming together—experts in all areas of health care—for months, to produce a plan and then discovering along the way that they do not even have basic data on things like what happens if you community rate all at once?

In other words, this is the most massively complex subject and this health care reform legislation will be the most massively complex legislation in the history of this institution. It is vast. It is enormous. It is intricate.

But my point is, do you not admit that in a sense that as we go into this new era, health care having become a subject for the public radar screen in the last several years, for public policy in the last 2 years, that you must have a staff of people who understand health care. Do you have such a staff?

Mr. EGAN. Yes, I think we do.

Senator ROCKEFELLER. What is your situation there?

Mr. EGAN. We have an entire Division, Litigation Division, which reports to me, which is our "Health Care Division."

Senator ROCKEFELLER. How big is that Division?

Mr. EGAN. I believe it is approximately 25 people or approximately 20 lawyers.

Senator ROCKEFELLER. Would you do me a favor and send me information about your staff including their backgrounds.

Mr. EGAN. Certainly. I certainly will.

Senator ROCKEFELLER. Do you see the point I am trying to make though? On the one hand we are discussing antitrust issues like those back in the days of oil, right and wrong. It is fairly easy to figure out.

My point is that in health care there is incredible nuance, which can vary from county to county, and the difficulty will grow as we continue plowing into unknown territory.

And this is a real national emergency. We are not doing this just to reform health care. This is the only way we can save the economy. There can be no budget deficit reduction without health care reform and cost containment. The drive for cost containment is sacred. It is on the tablet from Moses. It has really got to happen.

And people are rapidly going to be making very, very complicated decisions, or deciding not to make decisions, based upon their perception. You understand what I am saying. I am repeating myself and I think Mr. Egan wants to say something.

Mr. EGAN. Yes. Can I just conclude by making one point? First of all, I am not here to say that managed care is good or managed cared is bad. Our role at the FTC is to simply assure that whatever direction the government decides to go with health care, that presumably it is going to have some aspects of competition to it. And that antitrust is important if that is going to work.

If it is decided, for example, to allow certain firms to allocate services in particular markets, I think the conclusion which has to be drawn from that, which I think was already suggested by Mr. Proger, is that you do not allow the providers then to decide what the prices are going to be.

I think antitrust has worked and does not stand in the way and it can assure that you have a system in place, which does not mandate that the government set the prices. So the option is not between having antitrust enforcement or simply letting the hospitals decide what the prices are, for example.

The option, it seems to me, is having an effective antitrust mechanism or going to some form of regulation.

Senator ROCKEFELLER. Let me expand one further thing.

Let's suppose that the President decides that cost containment has to start immediately. We are going to spend $1 trillion next year and $2 trillion 6 years after that. So it has to start immediately.

So you can do it on a regulatory basis, all payer style, or you can do it by saying to physicians as a group, to hospitals as a group, to pharmaceutical companies as a group that you can do it voluntarily.

When Candidate Clinton gave his speech in Rahway, New Jersey at Merck, in which he said that if prescription drug companies raise the prices of their prescription drugs by more than the rate

of inflation, they would lose their section 936 tax credits in Puerto Rico worth billions of dollars.

A month later, still well before the election, the pharmaceutical association, the PMA, came into my office en masse and said, we are willing to do this ourselves on a voluntary basis. Not only that, we will not only include the American companies that the candidate was talking about, but also the subsidiaries of internationals, et cetera, if you do not put it into the law.

Now physicians are business people in one sense but are not in most senses. They are practicing medicine. And the AMA is less than 50 percent of physicians. There are all kinds of physician associations, all kinds of subspecialties and subsubspecialties and I mean they do not talk to each other.

In medical schools they do not talk to each other. This is a very elite, discreet, boxed in group. And the same with hospitals to a lesser degree. The same with pharmaceutical companies to a lesser degree.

Now if the President comes forward with a directive to restrain costs on a voluntary basis, and there is a real possibility, how are they even going to be able to discuss how they would go about it? How are they even going to proceed to discuss how they might efficiently reduce their cost?

Because if we give them the clearance to do this voluntarily, there will be standby regulatory authority in case they fail to so do. So the pressure on them to do effective cost containment is going to be vast and, in fact, there will be very little time for it.

Now how are they going to do this without colluding? How could they possible do it?

Mr. EGAN. Well, I guess my question would be, why do they need to collude? I do not want to step on the toes of the Justice Department because I believe the question of the pharmaceutical firms, there is a request for an advisory opinion from the Justice Department, a business review letter from the Justice Department pending. I do not want to step on their toes.

But if the President proposes to any group that they hold price increases to a certain level, why do firms have to do anything other than say, yes, that is what I will do? Why do they have to get together?

Senator ROCKEFELLER. Because, it is going to be the aggregate amount that is examined. It is not going to be, you know, Dr. Stephen Jones in Wichita, Kansas. It is going to be every physician across the country. And, in fact, it may be total health care costs, and, therefore, insurance companies may be included. It will potentially be an aggregate amount that the total health care providing community will have to achieve as a certain result. It may be stated. It may be unstated as to what that result should be.

So an individual hospital could not possibly say I am going to do this and not know what others are going to do.

Mr. EGAN. I guess, Senator, I am sorry, I do not understand why. If the President said hold your price increases to the level of inflation, for example, if a given hospital said, yes, I will do that, and its competitors said I will not do that, then what would happen? Presumably is, that hospital would gain business and the other ones would lose business.

Senator ROCKEFELLER. Well, but see that is taking everything as the status quo. That is taking into case the distribution of all the MRI's. It is going to be very clear that some hospitals should do certain sets of procedures and others should do other sets. It would have to be a division of labor. There cannot be cost containment.

We are talking about dramatic cost containment, radical cost containment. This is something I am not going to talk about at length here but it is something I want you to think about. It is a massive process which they will have to attend to almost immediately.

I do not know how physicians as a group, much less subspecialties and specialties within the group called physicians go about doing this without getting together to discuss it. I mean, I would actually feel fairly nervous if they did not get together to discuss it.

Could they intelligently take Charleston, West Virginia and allocate resources so that they could get the maximum bang for the buck and still provide resources for cardiology and prenatal care for all citizens? The citizens might have to change where they have gone, to the hospitals that they go to or even the doctors that they go to.

It just may have to work out that way in order to really achieve the necessary cost containment, otherwise we will never reduce the budget deficit. I mean this is a very new really, really hard situation unprecedented in the history of the country.

Mr. EGAN. Again, my only concern would be are we left with a situation that a single hospital, for example, is the monopolist on a given service. And if there is government regulation of prices, then the decision on what prices to charge is left with the monopolist.

Senator ROCKEFELLER. Did you want to say something?

Mr. PROGER. Well, it is a very hard subject and it is a fascinating one.

Senator ROCKEFELLER. Dr. Cooper, you want to, too.

Mr. PROGER. Briefly two points. One is, I am very sympathetic to the perception issue. I think that hospitals and physician groups by and large are comprised of well-intentioned individuals trying to do the right thing.

I think in fairness to the people sitting to my left, who I spend my life opposing instead of agreeing with, I think they really are trying to get the word out and I really do think their enforcement policies have been very rational.

Senator ROCKEFELLER. Mr. Proger, I am talking about a whole new world.

Mr. PROGER. But, we have tried health planning. We had a statute, 93–641, a planning act. It did not work. I think managed competition will work because it already is working in Minnesota, California and many other markets.

The antitrust laws are going to be a barrier. They have not been a barrier to managed care and will not be in the future. Moreover, there is the doctrine of implied repeal and there can be express exemptions. In sum, I just do not think that antitrust is going to stand in the way.

Finally, I note that I have been there when the reason why a hospital merger or joint venture did not get done had nothing to do with the antitrust laws. There is a complex set of reasons that have nothing to do with the antitrust laws why ventures do not happen. In the final analysis, the issue is who makes the decisions. Should it be competition or a governmental agency.

I am always concerned about the capability of the government to make those decisions.

Senator ROCKEFELLER. Dr. Cooper?

Ms. COOPER. First of all, I feel in all candor I have to tell you, I am not Dr. Cooper but Ms. Cooper.

Senator ROCKEFELLER. That is what your name plate says. I started out by calling you Ms. Cooper, but then I looked right at it and said Dr. Cooper, so I was not going to short change you. [Laughter.]

Ms. COOPER. If only all problems were that easy to solve. I have to say that I do agree with Mr. Egan that there has to be some kind of control, whether it is market control through competition and antitrust laws or whether it is regulatory control.

I am somewhat mistrustful of saying we will let the industry decide. We will let the industry allocate among itself so that we have essentially a series of monopolists.

Senator ROCKEFELLER. You may be mistrustful of that, but this may be the policy of the President of the United States and ratified by the U.S. Congress. And, in fact, it would not even be said. It would not be said that you, cardiologist, will hold your increases down to 7 percent and you, radiologist, because you make a bit more money, you will hold yours down to something else.

I think it is probably going to be we as a country will not spend more than X amount of dollars next year on health care and you, the provider community, has to come up and meet that figure. If you do not do it within a year and a half or whatever, then we are going to come and regulate it, do it that way.

Now how can they go at this?

Ms. COOPER. Well, if potentially we have something in the nature of accountable health plans, then perhaps what we are going to end up with is groups of different types of providers getting together and figuring out how they can put together a package that would meet that goal.

Senator ROCKEFELLER. But this is before that comes into effect. You see, the point is, the cost containment will have to take place before the accountable health plans, before the health alliances and before all of that infrastructure architecture gets put into place. It is what we have to do on an interim basis so that we do not spend $700 billion more money while the architecture is being put into place.

Now I grant you when we get the architecture that will solve a lot of those problems. It is the interim point that I am worried about. I do not want to press the point. All I am saying is, I guess I really want all of you to think about that, and particularly, Mr. Egan.

I mean it really is unchartered territory into which we are walking. And we must be able to contain the cost of health care, with 100,000 people losing their health insurance every month, bank-

ruptcies by the thousands, it has got to be done and it has got to be done in fairly draconian, brutal and rapid fashion.

I just want you to open your minds to the possibilities of consequences of some of the things that might have to take place in the national interest for that to happen.

Any last word?

[No audible response.]

Senator ROCKEFELLER. I really appreciate you all coming. It is an incredibly important subject. It is important to me. I am not a lawyer. I need to learn these things. I need to know these things. I need to be sensitive to the issues that you raise as well as the issues that are raised to me by providers. That is why we have held this hearing.

So I really thank you very much.

Mr. EGAN. Thank you.

Ms. COOPER. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Our final panel, and I issue a blanket apology to all of them, Jerald R. Schenken, M.D., member of the board of trustees of the American Medical Association, Omaha, NE; Erling Hansen, general counsel, Group Health Association of America, Washington, DC; Beverly Malone, Ph.D., dean and professor of the School of Nursing, North Carolina A&T University in Greensboro on behalf of the American Nurses Association; Eugene Pawlowski, president, Bluefield Regional Medical Center, Bluefield Health Systems on behalf of the American Hospital Association; and Steve Wetzell, executive director of Business Health Care Action Group, Minnetonka, MN.

Dr. Schenken, since you are first on the list, why don't we start with you?

Dr. SCHENKEN. Thank you, Mr. Chairman. I just would make one informal comment before I start. I was interested in Mr. Proger's comment that all antitrust laws are clear to everyone. You know, neurosurgery is very clear to me, too. But antitrust laws are not clear to most of us, most of us physicians that are out there in the world, and we do have a problem.

Senator ROCKEFELLER. Although he did quote, and then it became unclear to me whether it was AMA or AHA.

Dr. SCHENKEN. AHA.

Senator ROCKEFELLER. All right. Well, then the AHA person, Dr. Pawlowski, you will maybe respond to that, because he did quote from that saying this is reasonably clear.

Please proceed, sir.

STATEMENT OF JERALD R. SCHENKEN, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, OMAHA, NE

Dr. SCHENKEN. Mr. Chairman, I am a pathologist in private practice in Omaha, Nebraska. The AMA appreciates this opportunity to address the antitrust environment and its impact on the evolving health care delivery system. In fact, we believe that antitrust law and enforcement activities must be modified in tandem with the reform of our health care system.

Let me say at the outset the AMA does not seek an exemption from the antitrust laws for physicians. The relief it seeks is limited and is designed not to protect fee-for-service, but precisely to allow

physicians to form integrated ventures and other competitive alternatives. Problems and solutions from yesterday should not blind us from solutions for tomorrow.

Since the 1975 ruling in the Goldfarb case, physicians who have attempted to negotiate collectively with third-party payers through a professional organization or a joint marketing venture have been at times subjected to criminal investigation and/or civil penalties.

While the courts have increasingly come to recognize the unique role of health care providers by applying a more flexible legal standard then either the FTC or the Justice, the enforcement arm continues to prosecute.

For at least 10 years, government enforcement agencies and private antitrust counsel have sent physicians a consistent message. Collective actions by physicians, including legitimate peer review and sorely needed disciplinary actions, carry a high level of antitrust risk.

Indeed, the mere threat of antitrust challenge has the most chilling affect imaginable upon peer review and self-discipline. Later in the Q&A I would be glad to provide whatever examples you would need to explain how this has occurred.

Managed competition will increasingly require physicians to act in a coordinated manner. In order to respond meaningfully, physicians must be able to respond collectively. Although the clarification we seek could be accomplished within the authority of the enforcement agencies, statutory action would be an important guarantee to facilitate physician negotiations with managed care plans and other third party payers, as well as providing consistency to FTC interpretations and actions.

And it is this consistency that is perhaps more important than anything else we seek. In order to present their views to managed care plans, collective physician input is needed to act as a balance on issues of quality of care, program administration, and payment for care provided.

For example, since referrals within the system are restricted, what voice will primary care physicians have if they feel that the quality of surgical consultants forced within the plan is not satisfactory?

From both my point of view as a physician, and as a potential patient in need of care, the antitrust laws should not prohibit physicians affiliated with managed care plans from collectively providing information to the plan on issues ranging from medical review criteria, quality assurance coverage, medical policy and reimbursement decisions.

The AMA recommends that managed care plans established physician committees to advise plan management on these crucial issues. We support modifications of the Federal antitrust laws for medical self-regulatory entities which are designed to promote quality of care. These provisions were included in S. 3348 introduced by Senator Hatch in the 102d Congress and H.R. 47 as introduced by Representative Bill Archer in the 103d Congress.

The current antitrust statutes and enforcement activities severely restrict appropriate professional self-regulation and discipline by the medical community. Most State and county medical societies have committees designated to mediate and resolve pa-

tient grievances and to discipline members that engage in unethical conduct.

However, these committees have become virtually inactive or underused because of the threat of antitrust challenge. The AMA has filed a petition with the FTC seeking to remove limitations that restrict the medical profession from pursuing efforts to police itself.

Let me add, Mr. Chairman, civil risk is one thing. When it comes to fear, treble damages and criminal charges are quite another.

In conclusion, health care antitrust relief is needed to permit physicians to address the needs of today and properly respond to the challenge that you have so appropriately and succinctly presented to us this morning and at many other times.

Appropriate solutions, such as those that we have recommended, will contribute to the success of any model of health care system reform that is ultimately adopted. My message is really this, beware of unintended consequences. Give us back our chance to improve health quality which we had before all of the antitrust concerns arose.

Mr. Chairman, the AMA appreciates the opportunity to appear before the subcommittee today. We look forward to working with you. At this time I request that my written and/or oral statements, as well as the AMA's letter to Chairman Steiger be submitted for the record.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. They all are.

[The prepared statement of Dr. Schenken appears in the appendix.]

Senator ROCKEFELLER. Thank you, Dr. Schenken.

Mr. Hansen?

STATEMENT OF ERLING HANSEN, GENERAL COUNSEL, GROUP HEALTH ASSOCIATION OF AMERICA, WASHINGTON, DC

Mr. HANSEN. Good afternoon, Mr. Chairman and Senator Durenberger. HMO's and similar managed care systems have been able to develop and expand in part due to the capable enforcement of the antitrust laws by the Department of Justice, the Federal Trade Commission, State Attorneys General and the courts.

There are many examples, current and past, where any competitive obstacles have been removed by reasoned interpretation and enforcement of these laws. This will continue to be necessary under any health care reform scenario.

The success of a managed competition plan, in particular, will depend possibly in large part on a complementary antitrust policy. Antitrust laws have not chilled innovative and creative initiatives in managed care. In fact, just the opposite is true. There are diverse arrangements involving HMO's, PPO's, IPA's, physician/hospital joint ventures, community health care alliances, to name a few.

We agree with others on the need for a continuing clarification and understanding of the enforcement agencies views and intentions in some areas—joint ventures, mergers, exclusive dealing, among them. We would oppose any change, however, to make it harder to challenge and remedy concerted activities that improp-

erly obstruct managed care activities and restrain rather than promote competition.

GHAA believes that there is sufficient flexibility under current antitrust laws to foster continued growth and innovation in managed care arrangements in keeping with the health care reform approach envisioned and hopefully soon to be unveiled by the Administration.

When the reform program is announced, a managed competition environment could be created in which antitrust enforcement becomes more difficult. Rural America, where managed care is not now a significant factor may be a special challenge.

As in the past, antitrust officials will be challenged to recognize new efficiencies and to fashion remedies to potential new anti-competitive conduct. We believe that they will succeed without the need to amend the basic antitrust laws, that in less than 20 years have been brought to bear most constructively to the health care arena.

In our written statement we suggest other non-antitrust laws over which this subcommittee does have jurisdiction where legislative intervention could officially clarify the types of affiliations that health plans may have with providers and that providers may have with other providers regarding participation and managed care initiatives.

Thank you for this opportunity to testify.

Senator ROCKEFELLER. Thank you, Mr. Hansen.

[The prepared statement of Mr. Hansen appears in the appendix.]

Senator ROCKEFELLER. I turned to Senator Durenberger and I said, we are trying to figure out why you and the AMA have such different views. I guess we can partly understand it. But I told Senator Durenberger since he is a very smart lawyer I would assign him that responsibility and then he could tell me.

Dr. Malone?

STATEMENT OF BEVERLY MALONE, PH.D., R.N., F.A.A.N., DEAN AND PROFESSOR, SCHOOL OF NURSING, NORTH CAROLINA A&T UNIVERSITY, GREENSBORO, NC, ON BEHALF OF THE AMERICAN NURSES ASSOCIATION

Dr. MALONE. Thank you, sir. I am Beverly Malone, Dean of Nursing at North Carolina A&T State University. I am a clinical nurse specialist and a licensed clinical psychologist and have practiced individual, group and family therapy for over 19 years.

I appear today on behalf of the American Nurses Association and we are very pleased that you are holding this hearing. We advocate the coordination and collaboration of health care services and believe that multi-disciplinary provision of preventative and primary care services is cost effective. Getting the care to the patient is our major concern.

Health care reform must not repeat the existing delivery financing and workforce problems. The focus on cost containment should not be used as an argument to remove protections against antitrust. The President's Health Care Reform Task Force has focused on managed competition. Conceptually, we agree with its goal.

But the playing field must be level to promote competition. Nurses can compete if the field is fair. Anti-competitive barriers, for example, unnecessary practice act restrictions, over-regulation of nonphysicians, unnecessary limitations on prescriptive authority and hospital admitting privileges and lack of third party reimbursement must be removed to allow nurses to provide health care services.

Advanced practice nurses emphasize health promotion and disease prevention. Their primary health care functions include health assessment, physical examination, development of a plan of care, instruction and counseling, use of laboratory data, diagnosis of routine illness, prescription of medications, coordination of services and necessary referrals.

Three Federal health programs recognize advanced practice nurses—OBRA 1989, mandated direct Medicaid reimbursement to pediatric and family nurse practitioners and OBRA 1990 mandated direct Medicare reimbursement to nurse practitioners and clinical nurse specialists who serve in rural areas.

FEHBP since 1990, reimburses advanced practice nurses for covered services. There are still enormous changes that must be made. Restrictive policies based upon specialty or geographic location must be removed. Medicaid payment policies need to be improved and be based on service delivered, not the type of provider.

Barriers imposed by regulation, legislation or custom include the use of practice arrangements to limit the activity of advanced practice nurses. Inconsistencies in definitions of advanced practice and scope of practice varies from State-to-State and does not reflect the education and clinical expertise of advanced practice nurses.

Prescriptive authority and hospital admitting privileges have been limited through the use of protocols and requirements for supervision and physician intervention. The use of expensive medical practice acts, which classify every health care action as a delegated medical function, limit the scope of nursing practice.

Other barriers are the limitation on the availability and accessibility of liability coverage and use of insurance surcharges to increase malpractice premium coverage and impede physician-nurse collaboration. Nurses report anti-competitive behavior in many States. Provider actions restrict nurse participation in professional groups, liability programs and marketplace.

In Tennessee, nurse midwives won a legal challenge to reverse restrictions on hospital admitting privileges. In Alabama an insurance coverage sponsored by the State Medical Association prohibits physicians from acting as off-site preceptors to advanced practice nurses.

Therefore, midwives cannot deliver babies without a physician being present and nurse practitioners cannot practice in rural areas. These actions discourage integrated, coordinated, collaborative, care delivery and foster costly and unnecessary duplication and gatekeeper functions. ANA recommends expanding health care provider choice to include all qualified health care providers.

The following actions are recommended for your consideration: (1) Medicaid and Medicare policies must be amended. ANA supports S.466 and H.R. 1683 as well as S. 833 to provide direct Medicaid and Medicare reimbursement to advanced practice nurses. (2)

Encourage proactive FTC enforcement. (3) Make all Federal health insurance programs, including Medicaid and Medicare consistent in coverage of services and choice of providers. (4) Strengthen implementation of Federal reimbursement policies, FEHB, Medicare, and Medicaid. (5) Use anti-discrimination language prohibiting discriminatory and restrictive payer practices. (6) Use financial incentives to encourage States to pursue amendments to regulatory and legislative language which would result in the most expansive practice parameters for qualified providers. (7) Remove exemption for the insurance industry under the McCarran-Ferguson Act.

Thank you for this opportunity to express the American Nurses Association's views on antitrust issues in the health care industry.

Senator ROCKEFELLER. Thank you, Dr. Malone.

[The prepared statement of Dr. Malone appears in the appendix.]

Senator ROCKEFELLER. Eugene Pawlowski—actually, your statement has more or less been given.

Mr. PAWLOWSKI. It sure has.

Senator ROCKEFELLER. Could I get you to respond to some of the points made by the FTC. For example, what would an expedited review mean to you. In your testimony you said that the for-profit hospital threatened to sue you because of your conversations with another non-profit hospital in Bluefield.

First, what were you hoping to accomplish with the other hospital? And were you planning a joint venture or a merger, and what is it that the other hospital was fearful of?

Mr. PAWLOWSKI. Okay. I think to respond to your questions you need to have a full background of why I am here today. Okay?

Senator ROCKEFELLER. You go right ahead. Withdraw what I have said.

Mr. PAWLOWSKI. First of all, I will try to answer your questions as I speak.

Senator ROCKEFELLER. All right.

STATEMENT OF EUGENE P. PAWLOWSKI, PRESIDENT, BLUEFIELD REGIONAL MEDICAL CENTER, BLUEFIELD HEALTH SYSTEMS, INC., BLUEFIELD, WV, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. PAWLOWSKI. I appreciate, Chairman Rockefeller, the chance to come up today to talk about health care reform and I represent the providers who do care about the patient. I think we always have to recognize that the patient comes first.

As you know, our State of West Virginia started 2½ years ago on health care reform. Our Governor, with your help, created a Health Care Planning Commission. I was one of seven members representing the health care industry.

We were concerned about three things. One, the quality of care. Number two, access, and finally the cost of care. We had five major task forces that we broke down into. The one I chaired focused on the health care delivery system.

My co-chair, as you may know, was the State Secretary of Health who is also an attorney. She now has left the State government and is a major partner in a law firm in Charleston. She, too, is concerned about antitrust.

The fear of antitrust risk came across very clearly in our deliberations on what we call the "systems" approach to health care. The first issue we talked about was competition. When you look at it—the studies, the presentations—we had over 2,000 people participate throughout the State, talking about a delivery system.

We can talk here for hours. But let me tell you, competition has been proven through studies to increase cost. It causes duplication. It causes inefficiencies. And sometimes it causes reduction of quality of care because we do not have enough volume.

The other thing competition caused was a cluster of too many profitable services in metropolitan areas, while other parts of our State have no services. Services that are nonprofitable are not provided because, again, the focus was on profitability and competition.

We had a lot of debate about how you formulate a community care network. We engaged a consultant—Rosenberg & Associates—to help the planning commission deliberate and give substance to what a community care network would look like, how it would function and whether cost savings would occur.

I would like to submit the report that the consultant gave to our Commission.

Senator ROCKEFELLER. Of course.

[The report appears in the appendix.]

Mr. PAWLOWSKI. Mercer County, WV was one of the test sites. We decided to use Princeton and Bluefield to show how a cooperative network would work. Before he did the study, Dr. Rosenberg asked two things.

First of all, he noted that the activity had to be under State direction because he feared antitrust risk. Number two, he wanted releases to protect him from antitrust risks personally. So the report was done under State guidance; the State Health Department worked through the Commission because of fear of antitrust.

The report documents, in Mercer County, a minimum of $1.5 million operating savings and a potential maximum of $5 million operating savings per year, to be achieved by having two hospitals work together to reduce duplication and to cooperate in order to provide better medical services.

I can spend hours talking about the report. Maybe in D.C. $1.5 to $5 million is a small amount. But as you said, change has to start some place and we need to start at the grassroots level. For us in Mercer County, $1.5 to $5 million annual savings is a lot of money.

The report was presented at a group hearing in Mercer County. The community leaders were excited. The Board of Directors was excited. The medical community reacted. We then created a coalition. The community said "great, let's talk about how we can work together. Let's talk about how this can happen."

That is where we got into difficulty with another institution in town, who basically told the other hospitals, "if you ever do meet again, we will definitely take action, personally and organizationally."

That kind of threat creates a lot of difficulty for business leaders. Today I would like to introduce our Board Chairman, Charlie Peters, who is a volunteer. Charlie Peters is in the audience here. He

gives us a lot of time. He is a full-time businessman. He is concerned about quality of care.

I do not want Charlie Peters or any other Board member or any business community person to be exposed to adverse publicity or to legal action. We did get legal opinions. Please note that I am not an attorney and will not be testifying today about legal matters.

Behind me is the Washington Counsel for the American Hospital Association, Gaelynn DeMartino. I would like to refer any technical questions about antitrust law to her, if you do not mind. Okay?

All the attorneys we consulted said, "yes, you probably could win. Yes, you probably could win an antitrust attack. But the cost, the effort, and the publicity is going to be very, very difficult. And the question to the community is, are you ready?"

Now we did introduce an antitrust provision into legislation. Tony Willis Miller, working on the Commission, felt that there had to be some legislative relief at the State level to allow the leaders at the local level to work together, to come up with what you said, drastic changes. The mindset has to change.

Yes, we are providing good quality care. Yes, we have some access. And we can improve access. But no question about it, the costs are getting prohibitive. We need to find innovative ways to eliminate duplication. We have to find innovative ways to create efficiency. We have leaders who took the initiative; every community is different.

One thing our Governor did say in a report and in his presentation is that we cannot have a rigid, one-fix approach from Charleston. Any solution has to be community-oriented. Parkersburg is different than Charleston. Bluefield is different than Morgantown. There are no simple solutions to this complex problem.

Likewise, a rigid solution from the Federal Government would not be appropriate. I am intimidated coming up here today. I feel very uncomfortable. The place to start is with community leaders, talking about the objectives, finding ways to get the leadership, the manpower, and the medical community working together to find innovative ways to provide access, quality of care and reduced cost.

We started Heartnet in 1985. Heartnet is a relationship between Bluefield a hospital in Roanoke. In 1987 it became official. The relationship is very simple. We wanted to have seamless treatment for the patient when he came into the health care system for primary, diagnostic, and heart conditions. If he needs a cardiac cath lab, he could go to Bluefield and if he needs to move on to a tertiary center for helicopter services and open heart surgery, he could go to Roanoke Memorial Hospital.

Our Heartnet relationship with 15 other hospitals triggered an antitrust lawsuit alleging violations between community hospitals and Roanoke Memorial. The hospitals spent $3 million on legal matters? Read the articles. Read the publicity that Roanoke Memorial received. That publicity, that money, stopped Heartnet and made the arrangement in effective due to threatened litigation.

Our next step was Cancernet and the third step was Wellnessnet. We felt back in 1987 that the communities could work together to improve access, quality and reduce cost. The trouble was the fear of antitrust risks—and if I was terrified before, after this hearing today I see what my attorneys say. It is a complicated

process and I do not know if I would want to proceed unless we have some protection from exposure to litigation for community leaders, myself and our board.

Senator ROCKEFELLER. Thank you, sir.

[The prepared statement of Mr. Pawlowski appears in the appendix.]

Senator ROCKEFELLER. Mr. Wetzell?

Senator DURENBERGER. Mr. Chairman, I will introduce Steve as a Human Resource Manager for the past 14 years. Currently he is the head of the business Health Care Action Group, in Minnesota.

We have what you might call a health alliance as the President is talking about, which is a large purchasing group for State employees.

State employees can buy accountable health plans through this group. To get into the Business Health Care Action Group, as you will hear, 16 big employers, about 175,000 enrollees, employees and their families and so forth, is kind of a combination of a health alliance or a purchasing group and an accountable health plan. Because as he will tell you they have blended the financing, the marketing and the linkages with everybody from the local medical establishment to the Mayo Clinic.

Steve is the only employee of this whole thing and he will give you some ideas of the problems or the potential that this arrangement has.

STATEMENT OF STEVE WETZELL, EXECUTIVE DIRECTOR, BUSINESS HEALTH CARE ACTION GROUP, MINNETONKA, MN

Mr. WETZELL. Thank you, Senator Durenberger; and thank you, Senator Rockefeller. I think the best thing I could do with my 5 minutes in the interest of health is just give it up and let everybody go for a walk right now.

I will be brief. What I would like to do is take the liberty to spend a few minutes to talk about what we are doing in Minneapolis. Allegedly, we found the tablets of stone to health care reform, so I will share our commandments.

Although I think the way to paraphrase what is going on in Minneapolis is a statement that we often use at our board level, in the land of the blind, the one-eyed man is king.

We have not found all the answers, but we think we have found a workable model. The response from the provider community has reinforced our belief that the private sector can fix the system with the minimum amount of interference from the regulatory environment. I will get to that later.

We are a group of 16 large employers. We are self-insured. We have about 175,000 lives represented. We represent about 8 percent of the market share in the Twin Cities community.

Presently, we anticipate continued growth. A lot of large employers like what we are doing. They are contacting us and we have an additional 8 or 10 employers in the wings that are talking about joining our coalition based on what we are accomplishing.

We believe that reform is based on several different components. It took us 50 years to screw up the system. We have all been a part of making the mess that we are all facing now and everybody is

going to have to make some changes to fix it and it is going to take more than a year to correct our problems.

We believe that quality is a key piece. Quality of care is the bottom line in what we are all about here. Competition is obviously a strong component of our model, being a private sector based model.

Increased consumer knowledge and accountability, the challenge we face with the entitled patient in the United States, may be our greatest challenge. It is dangerous for politicians to talk about that. But employee benefit folks face that every day. We see that and our providers have told us that our biggest challenge is educating patients on how they can better use the system.

And finally, we are pursuing enhanced efficiency through the use of protocols, guidelines, measurement of outcomes to really start using data not as a weapon but as a tool to facilitate continuous improvement with then competing provider systems.

We have agreed to a common plan design, and common administration. All 16 employers have agreed to the same set of rules. That took a year of half-day meetings, but it did get done. We are using something called point-of-service. When our employees use contracted providers, they get high benefit coverage. To protect freedom of choice, they can use noncontracted providers. Because that is a higher cost, there is a higher out-of-pocket expense for employees using non-contracted providers.

We have a joint organization with our contracted physicians to develop protocols and measure outcomes. So it is a purchaser/physician governed effort to define what is quality care in an accountable environment. We are working collaboratively to solve the problem, rather than adversarially.

We are also working on technology assessment and a very large emphasis on population health. The goal is to prevent illness instead of treating illness with the high cost associated with that.

Here are some of the financial results. We have administrative costs that are about 8 to 10 percent of the total plan costs because of the efficiencies gained by a group buying approach. Most of our dollars are going to treating patients, kind of a novel concept relative to what has been going on in the insurance industry over the last several years.

We have a 3-year trend guarantee on our costs with our providers. That trend guarantee is being reduced over the 3-year period relative to real growth in the economy, which is consistent with some of the concepts, Senator Rockefeller, we have talked about today with voluntary global budgeting.

Our first year savings are about 5 to 10 percent, compared to our old managed care products. Now keep in mind you are talking about a market that is already 15 percent below the national average. We have saved another 5 to 10 percent on top of that in the first year alone.

In terms of what all this means relative to the topic at hand, I am not an attorney and most of what I learned about antitrust I have learned in the last 2 hours. All I can say is it cost us $30,000 or $40,000 to find out that we were okay when we started this process. That was using an attorney that was pretty responsible and not spinning the meter on us.

I did not see antitrust as a big issue up to this point. It was kind of a nuisance. We are a large organization--$30,000 is not going to bankrupt us. To be quite candid, after all I have heard today, in all due respect to Senator Metzenbaum and Mr. Egan, I have a little more fear about the current antitrust environment than I had before I sat through these last 2 hours.

Writing a letter to Washington to get a private opinion letter is not going to work. I have waited years for private opinion letters and have never gotten responses and I just do not see the system able to respond quickly enough for the massive reform that is coming.

I did not have that opinion, that strong of an opinion before I come today. But listening the last couple hours, that is how I feel now.

So as far as antitrust reform, I think we need a firmer definition, clearer rules, on what is permissible behavior and what is not permissible behavior. There is still obviously a role for antitrust control as the system reforms itself.

But I do not see why we cannot sit down and come up with clearer rules that people can use without having to go through a long, legal process to get approval for all the reform that is coming.

And finally—the bell has rung. That is appropriate because I am going to deviate from the topic now.

Representing self-insured employers, I do have to make a couple comments on ERISA because the customers that I represent in this coalition are large self-insured employers. They are protected from State regulation by ERISA and without that protection our initiative would have never started.

So we do have fear as we start debating health care reform, that if we lose that protection under ERISA a lot of very positive things that can come from the private sector will be lost. We would argue that ERISA should be expanded in one area that we have already identified to allow us to direct contract with our providers on a capitated basis. Right now we cannot do that without being regulated like an insurance industry. That does limit our ability to do some creative things with provider reimbursement.

Thanks for the time.

Senator ROCKEFELLER. Thank you.

[The prepared statement of Mr. Wetzell appears in the appendix.]

Senator ROCKEFELLER. Senator Durenberger?

Senator DURENBERGER. Steve, thanks very much. I think you got an awful lot in there in a relatively short period of time and I appreciate your coming. I appreciate everyone else being here as well.

I want to back up to where I was an hour-and-a-half ago for laying the premise for the future which is that as we talk about antitrust and that we want people to get quality products for a reasonable price, and medicine, just an example of a market in medical care. We do not know what quality is.

The nurses tell us that all the time. They tell us they are a real bargain, a real value. We are not responding to that value in the same way we do to other values. But we do not know how to measure quality, we do not know how to measure value. We do not know what price is relative to anything in this marketplace be-

cause we have all been insensitized. We do not have enough information.

The information we have is all about the wrong things. We make presumptions that the more you pay somebody, the better they must be. That ain't necessarily true. Just go down to the Mayo Clinic or go to Minneapolis. You can find that out real quick.

I am sure all of you from Omaha, Nebraska and places like that. So we are going to change that. But it seems like one of the changes that has to be made, if we are going to go to some kind of a medical market in this country, is we are going to have to deal with the reality that the decisionmakers in the current system are the doctors.

Is that appropriate or inappropriate? I happen to think it is appropriate. It is just that they are making them on the wrong basis right now and we are getting a lot of medicine we do not need. We are getting a lot of drugs we do not need. We are getting a lot of inappropriate stuff in the system.

But I still believe the notion that if there were doctors we would not have hospitals. Your hospital could not exist if doctors decided not to go to your hospital.

So the medical professional, whoever is our entry point in the system, has to be in a position where they can do the best for us. And the current system does not really give you that.

What is the proposal? The proposal is to arm consumers with more of the right kind of information so that they will go to and listen to the right kind of professionals who will do for us what needs to get done. One of the ways to do that is to group us all up in large groups called health alliances, to use the Administration's term, or a health care action group or somebody like that, where with the power that large numbers of people have uniquely from a single person, they can say, we want to buy accountable health plans.

We do not want to just buy doctors and hospitals. We want to buy an accountable health plan. That health plan will provide us with the opportunity from year to year to determine what are these services that we are supposed to get from the medical community and can we not get more and better services than we are getting currently?

That could go on and on. But, I mean, that is the thesis of all of this. What the Health Care Action Group, for example, is doing in Minnesota is even though it is put together by employers, it is trying to make sure the employees are playing in this game, that they actually do make decisions every year and that they benefit from the decisions that they make.

As Mr. Proger said earlier, the only way you are going to get efficiency in this system is if the efficiency goes back to the consumer. If, in fact, the consumer who makes a good buy and uses a good plan actually sees some benefit from that in increased value and better prices and so forth.

Now that means that the delivery system in medicine is going to change. There is no question about it. And maybe what, you know, what Dr. Malone said about nursing, some of that will come true, some of it will not. I mean, who is going to be working with whom in the future is going to be very difficult, very difficult to tell.

For sure, we are going to be abandoning fee-for-service medicine. We are not going to be buying 9,000 discreet products because that is not an efficient way to do it. But I do not think it is our job to tell anybody what this market ought to look like. That is one of the issues that we get into here when we are talking about who makes these decisions.

There is an effort in America today in my State and some other States, to control the prices of medicine by controlling what a network looks like and who is going to be in it and who is going to be out of it. And under the guise of the State immunity doctrine, I think these States will be trying to do something like that.

We have the harder sell, those of us who are the more market oriented folks, we have the harder sell because we haven't got anything to prove that we are right. We do not have a functioning market. We become very dependent on the doctors and the nurses and everybody out there to show us how we can do these things better than we are doing them now.

I want to ask the medical professionals—the nurses, the doctors, and so forth—what your particular views are relative to preserving competition, preserving the opportunity that you have as a professional, make the best possible choice you can and to be rewarded for that in the system and where do you think impediments may come in the way the current system runs or in the way some of the stuff you hear about managed competition in the future, where there may be curbs in your doing for the individual consumer what needs to be done.

Jerry?

Dr. SCHENKEN. I will give you a brief answer because I think you just want some examples. I guess our concern is that we have felt that competition, that the term managed competition is an inconsistent term from the beginning, and that the same is probably true with competition and quality. Because at some point in time to maintain a level of quality, you eliminate competition if all quality comes up to a certain level.

Competition also can improve quality, depending on how it is done. But, for instance, we have opposed on many occasions competitive bidding for medical services on Medicaid and now there are so many examples fraudulent conduct, that is how the pap smear started. It was all on a competitive bidding basis that was forced down below what the system would take.

So I guess our concern is, we are not asking for an exemption from the antitrust laws. We are asking for understanding and consistency, but we do not believe that all of these accountable health services have to be the same. There should be competition in design, implementation. And we also do not feel they should be all big business.

Now it is all well and good to have the finest or one of the finest medical centers in the world in your State. I agree with that. We send a lot of our patients up to the Mayo Clinic. And those doctors all work together so they have no antitrust problem.

But our physicians in western Nebraska who are present in twos and threes and fours also have some joint interest on how the health of Nebraska comes down and we need some opportunity for the small practitioners to work together to do the same thing.

I guess that is what we are asking for. If we are going to have competition, leave flexibility within the system.

Mr. PAWLOWSKI. I think that is the key point. The American Hospital Association and the West Virginia Hospital Association talk about provider care networks as community based. There is room for multiple networks. There does not have to be only one.

But what is happening now is the fear of antitrust. The perception is forbidding people from getting together to talk about it. You really need the leadership, the creativity, the ability to find two, three, or four providers to do whatever it takes.

So I think we are impeding ourselves. We are getting dichotomy and different messages here. Yes, work together. Yes, collaborate. But if you do, you may be subject to antitrust. So you have to find that balance in between.

Dr. MALONE. In nursing it is kind of different. We want to make sure we are among the groups that are consulted. We want to make sure that we are there to provide services. The system that we have been living with has been one in which we have had to fight for space, even though all the data that comes in shows that we give good care and that we are there in locations where other people are not. We are in the rural areas.

And we work in the inner cities. Whether you are talking about major urban areas or rural areas, nurses are there. But we do not always have access and we find that the system is organized in a way, historically and philosophically, that excludes nursing. To allow us the opportunity to practice to the full scope is what we are really about.

So we are asking for protection with the antitrust legislation, because that has been a primary way that we have been able to fight this battle. It has been an uphill battle for nursing. We look at the reformed health care system and we say we will get a chance to deliver the care to the people. When it is said that it must be more cost effective, nursing is there. When it is said that it must be delivered in a quality way, nursing is there.

We want to ensure that we have the opportunity. It has been very difficult to make sure that nurses have the opportunity to practice.

Senator ROCKEFELLER. Let me ask what I consider to be a really crucial question here. And that is, if the President decides to say to the provider community, physicians, hospital folks, pharmaceutical companies, perhaps insurance companies, we will see, that we are going to let you, the provider community, self-cost contain. We have to reduce the cost of health care dramatically.

But let's say that we are not going to take the regulatory approach, which we could do, and not set rates, and not set prices. But say to the provider community, you go ahead and do it. Let's see how well you can do it. You said you can do it. Let's see.

Now how are you going to go about doing that as you individually see it without invoking somebody coming up against you saying, you are breaking antitrust law? I will start with you.

Dr. SCHENKEN. Mr. Chairman, it is not going to be possible. For example, again, take Nebraska. We have an aging population. We are the fifth oldest state in the Union. We cannot get together and decide how much we are going to allocate to rural care in Ne-

braska, the best health care is transportation in order to get the really sick people transported to Omaha, to Lincoln, to Sconts Bluff.

So we are going to have to make a decision as to whether we allocate it to infants and children, neonatal. All those decisions are going to be made by small groups of doctors over a huge State. We are 76,000 square miles. That is basically what we are saying, that if we are going to respond to that and many other questions, the doctors are going to have to talk together, both for personal medical goals, but also for community medical goals.

I think we heard quite clearly the problem elucidated that came from West Virginia.

Senator ROCKEFELLER. Well, Gene Pawlowski, let me ask you, not just the West Virginia State health care plan, but supposing Federal legislation suddenly says to the hospital community, the entire cost of health care cannot increase next year by more than X amount of dollars.

Now the hospital community, the physician community, the pharmaceutical community, the provider community, you all decide how you are going to do it. We will give you a chance to do it. You said you can do it, let's see if you can do it. How would you possible go about it without violating antitrust laws?

Mr. PAWLOWSKI. Senator, the best example I can give you is our task force on system reform. Being a State task force we did have protection. We had four Chairmen, community leaders, medical staff, and nurses come together and talk. You would be surprised how many people recognized that there are inefficiencies in the system.

The freedom of talking and working together in a protected environment showed. And if you read the report Dr. Rosenberg prepared, that is clear. Okay? You need to have antitrust protection.

If providers perceive that they are going to be attacked by another hospital, by a disenchanted doctor, or by some other disenchanted person who is not part of the arrangement, then you are not going to have the openness and freedom necessary.

So I think the key is to give the people some protection so they can open up and say, for example, 50 percent or 40 percent OB utilization in two hospitals is not the most efficient way of providing care. Let's combine and have an 80 percent utilization.

We can improve efficiency. We can improve effectiveness and reduce cost. But, you have to have antitrust protection. If you do not, then you are going to have people like myself and others look at the interests of their organizations. The mindset right now with competition requires my priority, unfortunately, to be maximization of my institution's position in the market.

If I can change my mindset and say that my priority is not Bluefield Regional Medical Center, but the good of the community, and then ask how we attack the health care problem, we can achieve better health care delivery. We need to get the mindset changed.

Senator ROCKEFELLER. Well, it will be changed. It will have to be different.

Mr. PAWLOWSKI. Right.

Senator ROCKEFELLER. Because we will not be saying to you in Bluefield, West Virginia, at your particular hospital that you have

to reduce your cost of health care by X amount of dollars. We are going to be saying to hospitals and to health care all across America—hospitals, physicians, pharmaceuticals and others—you can spend no more in the aggregate on health care as a nation next year than X amount of dollars.

So you cannot just do it individually. You have to do it in collaboration with others or else it will be a totally random and absurd procedure, I would think.

Mr. PAWLOWSKI. That is the difficulty we are having. That is why we are saying the two messages conflict—collaborate, work together, reduce costs, improve access, improve quality. But at the same time, watch out for the antitrust regulatory people. You always have to be on guard.

You cannot even talk about collaboration if you are always in fear of something happening on antitrust issues.

Dr. MALONE. Mr. Chairman?

Senator ROCKEFELLER. Let me ask Mr. Hansen for a second. Excuse me, Dr. Malone.

Dr. MALONE. Sure.

Senator ROCKEFELLER. Your views now differ a little bit, I would suspect.

Mr. HANSEN. I think I am looking at this from the other end of the spectrum, yes. Because I do not think that the managed care industry would be fazed by what you are proposing if we are told that there is going to be a cap on budgets and where organizations have prospectively budgeted for the health care needs of the people that they care for. Then you have established what the budget shall be and then we go and negotiate with providers, physicians, yes, nurses and other providers to provide the care that we need within that budget.

I do not think that we have this problem of collective collaboration.

Senator ROCKEFELLER. See, but that budget is not a specific budget to your region. That budget is a national budget. So you do not have the freedom to say, this will not be a problem for us because we could just go to our providers.

We are talking about a whole country's health care system, voluntarily containing costs on its own. So by definition, you have to, be a part of the larger system and arrive at cost containment decisions in a collaborative way, I would think.

Mr. HANSEN. Well, you are setting up a system which almost seems too burdensome.

Senator ROCKEFELLER. Well, would you prefer that we do it them by setting rates, by telling you exactly what you are going to have?

Mr. HANSEN. You are suggesting perhaps——

Senator ROCKEFELLER. Remember the Southern California Edison wins all the prizes on managed care. They came in and said the cost of our health care is doubling every 6 years. We want a national cap on expenditures.

So I cannot assume, just because you are in managed care, that you have the answers.

Mr. HANSEN. No, that is true under that scenario. We have been sort of coming around to the thinking that these budgets are going to be perhaps on a State basis, which is a little more manageable.

If you are talking about a national budget and no other subdivisions, such as on a State basis, then perhaps GHAA has to get together with the American Hospital Association, the American Medical Association, and the 700 other or more associations in the health care arena and talk about how we do that.

Perhaps that would raise some antitrust issues.

Senator ROCKEFELLER. If that were to be the direction from Congress, would that, getting together with all of those groups, would that be inappropriate?

Mr. HANSEN. If Congress directed that it would be that way, then I think there would be an implied repeal of the antitrust laws as to that activity. But if Congress is, you know, less clear as to what its intent is, as to how the result will be achieved, then there could possibly be a problem.

Senator ROCKEFELLER. Dr. Malone?

Dr. MALONE. Nursing is different. We are right there at the bedside. We are right there in the community giving care to the patient. Our concern has been one of access to the patients and patients' access to nursing.

I am like on the Board of Trustees of a local hospital, and I am the first nurse that has ever been on that Board. In terms of the groups that you are talking about making decisions, they are going to eventually boil down to groups that have made medical decisions in the past, and those groups are without nurses for the most part.

One of my concerns is to ensure there is someone that has some power to say, that nursing is a group that has given quality cost-effective care to patients. Let them be included. Watch our legislation. Make sure that it does not prevent them from practicing. Make sure that there is a level of participation.

Senator ROCKEFELLER. But you are not answering my question. You are promoting your agenda.

Dr. MALONE. Yes.

Senator ROCKEFELLER. And I am happy for you to do that, but you are not answering my question.

Dr. MALONE. I think the system must begin on the local level. I think, yes, it is a national problem, but you have to build the infrastructure from the bottom up. You cannot start at the top without making sure that community-based care is being delivered cost effectively.

I believe all of us are going to have to begin by ensuring that the care we deliver in our communities, the kind of decisions we make, are ones where the providers who give the most cost effective care and are qualified are accessible to the public.

Senator ROCKEFELLER. But, you see, you are not answering my question at all, Dr. Malone. My question is, in the interim period of years—I do not reject what you are saying—but in the interim period of time, whether it is a year, 2 years or whatever, while we are containing costs and at the same time gradually building the architecture of health care reform in the new system, we will be saying to health care providers, how are you going to do this on a voluntary basis.

My question is, how would you go about doing that?

Dr. MALONE. Well, I do not see why we could not get together and do that. I do not see why the American Nurses Association, the

American Medical Association, all the folks here at the table could not sit down and at least begin to talk about problem solving.

I would think that that would be a very effective strategy, sir.

Senator ROCKEFELLER. See, my view is that that would be the most effective strategy. In fact, it is the only one that can possibly work because one of the problems with the health care system now is that medicine is split up into so many separate groups that do not communicate, that do their own work and have their own software and their own magazines they just do not work together.

By definition, we all suffer as a result of that, particularly on cost, and probably on care, too.

Mr. Wetzell, do you have some thoughts on this?

Mr. WETZELL. Well, it is a little hard to imagine all the players with all the regional variations sitting down together and agreeing to a voluntary global budget. I suppose it is doable but it would be a major task.

I have to support what Dr. Malone is saying. That one of the advantages of an approach that involves global budgeting within a system of care, an integrated system of care, not at a national or even a State level, is it does create incentives to use nursing more effectively. So that does tie into the antitrust issue.

Senator ROCKEFELLER. I am not arguing with that at all.

Mr. WETZELL. I think one of the key issues that has to be made if we are going to have a voluntary global budgeting approach is the issue of Federal reimbursement policy and some of the dysfunctional pricing that creates in the marketplace.

I would urge the Senator and the Legislature and the Executive Branch to consider government reimbursement policy and try to put that on a level playing field with private reimbursement. It is going to make the task of voluntary global budgeting a lot easier.

Right now with all the cost shifting that is going on between the public and private sector, that just adds another level of complexity in how we develop a voluntary global budget. So that would be another piece that would have to be looked at.

Senator ROCKEFELLER. Yes, sir?

Dr. SCHENKEN. Mr. Chairman, my answer to your question was a poor excuse of the word global. That is, at whatever level we are going to look at this cost containment. I am looking at more community or State levels.

Senator ROCKEFELLER. Yes, whether it is national, State or community, it is all the same problem.

Dr. SCHENKEN. Yes. Because I would not want to be interpreted as putting off the debate on the global budget, which is a much more complicated issue. We have not even discussed the issue of expectations and the publics responsibilities in all these things.

But it will be necessary for us, especially in rural States, if we are going to do anything, locally or whatever, to have at least clarification, which is what we have asked for, not exemption, to many of the confused answers that you got here earlier today.

Senator ROCKEFELLER. You know, all the questions that I have planned to ask you, I have not asked you. But I am going to, but not now. I am going to do it by letter. I do not want anybody here fainting from hunger, least of all myself.

Would you allow me to do that, to present questions to each of you separately, then for you to reply in writing within a couple of weeks to me.

Dr. SCHENKEN. Certainly.

[The questions appear in the appendix.]

Senator ROCKEFELLER. What I think is that people underestimate the enormity of what we are about to go through. I think we all do. And I think that, just working with the First Lady, after months and months of all of these experts, 60 physicians and people from everywhere, plenty of nurses and including one who sits right behind me who is a Registered Nurse and is at all of these meetings, that we have no idea of what we are getting into, the enormity of it.

I do not think the health care community is prepared for it, but you are going to have to because it is going to happen before we adjourn this year. Before Christmas Day we will pass in Congress legislation that will cause an enormous amount of change on the part of health care, on the part of the American consumers, on the part of all of us.

It is the most massive legislation in history. We have got to do it wisely. I think one of the things that is going to happen is that the health care community is going to have to sit down together, probably for the first time in American history, and talk about how it can make itself do its work better, both in terms of quality and cost.

My experience with medical schools and others is that health care professionals from the very beginning of their training are not taught or allowed or encouraged to be together. They learn on separate tracks. I have seen that and had medical students complain to me about that on numerous occasions—medical students of all kinds. I am talking about public health people as well as, physician assistants, nurse practitioners and nurses and physicians and everybody.

In any event, this is the start of a very long year and a very important year. You have been extremely patient, all of you, extremely patient. Do not think that because you have not been able to say all that you wanted to that what you have said is anything less than very important to me and to all of us as this becomes available to us.

I will send you more questions and I thank you very, very much.

[Whereupon, at 1:32 p.m., the hearing was adjourned.]

APPENDIX

Additional Material Submitted

Prepared Statement of Ellen S. Cooper

Mr. Chairman, I am Ellen Cooper, Assistant Attorney General and Chief of the Antitrust Division of the Maryland Attorney General's Office. I am also Chair of the Health Care Working Group of the National Association of Attorneys General (NAAG). On behalf of the Maryland Antitrust Division, I am pleased to testify on views of the antitrust implications of recent proposals to reform the nation's health care delivery system.

At the outset, I must state that the views I express are my own. I do not speak on behalf of any Attorney General nor do I represent the views of NAAG or any of its task forces, working groups or subcommittees.

I have been invited to comment on the antitrust implications of proposals to reform the nation's health care delivery system. My testimony is based upon three ideas:

1. The antitrust laws are flexible enough to accommodate most of the innovations that are being considered to restructure our health care system. Indeed, antitrust principles can help to ensure that the revised system functions at its most efficient level because they encourage market participants to find more economical and effective ways to bring a wide range of benefits to consumers.
2. Although under some circumstances the antitrust laws may restrict the ability of providers to implement all of the changes that a restructured health care system might require, any decision to abandon competitive principles should be the decision of the State governments, made to effect State policy. That decision should not be confided to private persons.
3. The States and State Attorneys General have a role to play in achieving the goals of health care reform.

The goals of the antitrust laws are consistent with the goals of the health care reform effort. Through competition, the cornerstone of antitrust, our nation seeks to promote innovation that offers consumers new and better products and services at the lowest prices possible. Historically, the antitrust laws have encouraged the development of such innovative and economical delivery systems as health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs"). The Federal Trade Commission, for example, has consistently challenged the efforts of traditional fee-for-service providers to exclude from the marketplace new types of competitors, such as HMOs and PPOs.[1]

Antitrust seeks to accomplish the goals of health care reform by prohibiting agreements or conspiracies among competitors that artificially raise prices or that reduce incentives to innovate and provide quality products and service. Price-fixing, bid-rigging, and boycotts are examples of such anticompetitive agreements. Antitrust also prevents dominant firms from "monopolizing," *i.e.,* exploiting their market positions to raise prices and to erect barriers that prevent new, lower cost providers from entering the market.

Antitrust laws can have a positive and necessary impact in the context of "managed competition," one of the frequently mentioned models for health care reform. "Managed competition" will create health care purchasing groups which are able to use their size and buying power to get the best care at the best price by selecting among integrated provider groups.

[1] *See. e.g., Eugene M. Addison. M.D.,* 111 F.T.C. 339 (1988) (consent order); *Medical Staff of Doctors' Hospital of Prince George's County,* 110 F.T.C. 476 (1988) (consent order).

Yet, there are dangers inherent in this rosy picture of reformed health care. What would happen if health care providers responded to these buying groups by banding together and agreeing, for example, that appendectomies would all be provided at the same cost or at what they deemed to be a reasonable cost? What would happen if five major groups of health care providers agreed that each provider would contract with one of five buying groups so that competition could be avoided? What would happen if health care providers agreed that they would not utilize certain new procedures or treatments unless all the providers agreed? What would be the impact of a collective decision by health care specialists in a community not to affiliate with a hospital or provider group that offered lower cost services provided by nurse-midwives or nurse-anesthetists? The answer is that in each case the buying group would be able to purchase health care only at an artificially inflated price. Moreover, since there is no pressure to offer innovative care in these examples, buying groups will not necessarily be able to purchase the best quality health care.

The antitrust laws would make each of these agreements among providers illegal. Indeed, federal antitrust enforcers have already prosecuted practices that could interfere with health care reform. For example, in 1991, the Federal Trade Commission prevented 23 obstetrician/gynecologists from forming a group to negotiate with third party payors.[2] The avowed purpose of the group was to fix the fees charged to third party payors and otherwise restrain competition among OB/GYNs in the Jacksonville, Florida area.

Also, 34 States including Maryland, working in tandem with the Federal Trade Commission, sued a pharmaceutical company for requiring that patients using its medication receive blood monitoring services from one designated source. In a 1992 settlement applicable to all 50 States, this anticompetitive practice was enjoined.[3] This practice, if unchecked, would have prevented all provider groups in a "managed competition setting" from even offering lower cost blood monitoring services to buyer groups.

Finally, the State of Maryland recently settled a case alleging that approximately 85 per cent of independent pharmacies in the Baltimore area had agreed to eliminate discounts on the copayments for prescription drugs, thereby raising consumers' health care costs.[4]

I am aware of the concern that antitrust law might not allow all of the innovations under consideration. For example, a proposal to create networks of health care providers may impact rural areas differently than urban areas. Rural markets frequently lack the availability of health care, much less the availability of competitive alternatives. One example of an innovation in rural health care is the creation of "satellite" treatment centers that would improve access to primary health care in rural communities. Congress established the Essential Access Community Hospital Program as part of the Omnibus Budget Reconciliation Act of 1989. Now a pilot program in seven States,[5] the EACH program was designed to assure the availability of essential services in rural areas. The program creates a "downsized" limited-service hospital called a Rural Primary Care Hospital which must establish a network with a supporting EACH facility. Participating States will establish a rural health plan, and approve facilities' applications for designation as an "EACH" or "RPCH" within a network if they are consistent with the rural health plan.

Although this proposal can allow providers who are normally in competition to cooperate and form agreements, the antitrust laws are not an obstacle. The antitrust laws do not seek to stifle collective efforts necessary to bring forth new products or services. To understand this proposition, it is necessary to focus briefly on a particular area of antitrust analysis—joint ventures.

Joint ventures, even joint ventures containing agreements among competitors that might be unlawful under other circumstances may be lawful if the pooling of resources, integration of functions and other cooperative aspects of the venture result in the introduction of a new product that would not have occurred absent the joint venture. One recent example is the cooperation among physicians necessary to form PPOs. Federal enforcement agencies have frequently approved as procompetitive PPOs that are controlled by fully integrated entities.[6]

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[2] *Southbank IPA, Inc.* 5 Trade Reg. Rep. (CCH) ¶23, 065 (1931) (consent decree).

[3] *In re Clozapine Antitrust Litigation,* MDL Docket No. 874 (N.D. Ill.).

[4] *Maryland ex rel. Curran* v. *Prescription Network of Maryland, Inc.* No. JH–90–2425 (D. Md., filed Sept. 17, 1990); *Maryland ex rel. Curran* v. *Giant Food. Inc.,* No. JH–90–2428 (D. Md., filed Sept. 17, 1990).

[5] (California, Colorado, Kansas, New York, North Carolina, South Dakota and West Virginia)

[6] *See e.g.,* Department of Justice Business Review Letter dated September 21, 1983; Federal Trade Commission letter dated June 22, 1983.

State Attorneys General have demonstrated a willingness to permit collaborative ventures necessary to enhance medical services provided that checks and balances are established to preserve competition to the greatest extent possible. For example, the Attorney General of Maine recently permitted a merger of anesthesiologists, despite antitrust concerns, on the condition that certain future forms of conduct that might have anticompetitive consequences be subject to review by the Attorney General of Maine.[7] Similarly, the Attorney General of Minnesota entered into a consent agreement that provisionally permitted a hospital merger to proceed. The settlement provided that the Commissioner of Health could require dissolution if it found that the merger did not result in lower health care costs or greater access to quality of care than a competitive market could provide.[8]

I cannot claim, of course, that the antitrust laws will permit every joint venture or every instance where health care providers might wish to collaborate. For this reason, some health care providers argue that they need an exemption from the antitrust laws. They would then be free to collaborate to eliminate excess capacity, reduce costs and allocate health care assets. However well-intentioned these providers may be, the fact is that they are caught between conflicting interests. Like all people in business, health care providers are understandably driven by the need to keep patients coming to them and to act in a manner that brings them the greatest revenue flow. I fear that these normal and lawful motivations would interfere with and perhaps hinder the realization of the altruistic motives that lie at the heart of the health care reform process.

State government, not the private sector, should be vested with the power to determine whether and when the antitrust laws ought to stand aside to permit collaboration. After all, State governments are responsible for the welfare of all their citizens, both consumers and corporate. State officials are elected and, as such, may be held accountable by the citizens of their States.

Current antitrust law provides the States with a long established mechanism for superseding the antitrust laws when necessary: the State action immunity doctrine. Under this doctrine, federal law allows States to exempt particular conduct from antitrust scrutiny by substituting regulation for competition.

As an initial matter, actions of the State itself are not subject to the Sherman Act.[9] The State action immunity doctrine further exempts from antitrust scrutiny those activities which are undertaken in the implementation of state policy, provided that the policy is clearly articulated and the actions taken are actively supervised by the state. The two-prong test for State action immunity requires that the anticompetitive actions of private parties be taken (1) pursuant to clearly articulated and affirmatively expressed policy by the State to supplant competition with regulation; and (2) subject to active State supervision.[10] Anticompetitive actions of private parties must be authorized by the State but not necessarily compelled.[11] Further, they must be reasonably foreseeable, given that authority.[12] Finally, the State must actually have and exercise ultimate control over private anticompetitive activities in a manner sufficient to make the activity the product of deliberate State intervention.[13]

Recent legislative initiatives by three States, Maine, Montana and Washington, demonstrate that States are able and willing to undertake the hard work of scrutinizing proposals to determine if their citizens' need for health care alternatives ought to supersede the important role of competition in our economic system.

Maine's recent legislation, known as the Hospital Cooperation Act, 22 M.R.S. §1881 *et seq.* permits a hospital to negotiate and enter into cooperative agreements with other hospitals in the State if the likely benefits resulting from the agreements outweigh any disadvantages attributable to a reduction in competition that may result from the agreements. The Maine Attorney General is given the responsibility for monitoring the effects on competition of such cooperative agreements and enjoining their operation if the benefits do not outweigh the disadvantages stemming from reduction in competition. The Maine legislature found that while hospitals are in the best position to identify and structure voluntary cooperative arrangements that enhance quality of care, improve access and achieve cost-efficiency1 regulatory and judicial oversight of those arrangements is necessary to ensure that the benefits out-

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[7] *State of Maine* v. *Mid Coast Anesthesia P.A.*, 1991–2 Trade Cas. (CCH) ¶69, 683 (Me. super. Ct. 1992).

[8] *Minnesota* v. *Health One Corp.*, Cir. No. 3–92–419 (D. Minn. filed June 22, 1992).

[9] *Parker* v. *Brown*, 317 U.S. 341 (1943).

[10] *California Retail Liquor Dealers Association* v. *Midcal Aluminum*, 445 U.S. 97 (1980).

[11] *Southern Motor Carriers Rate Conference* v. *United States*, 471 U.S. 48 (1985).

[12] *Town of Hallie* v. *City of Eau Claire*, 471 U.S. 34 (1985).

[13] *Federal Trade Commission* v. *Ticor Title Insurance*, 112 S. Ct. 2169 (1992).

weigh the negative effects of restraining competition in the market for health care services. Montana's recently proposed legislation is substantively similar to Maine's.

Washington's recent legislation exempts from State antitrust laws and provides state action immunity from federal antitrust laws, activities in the health care industry taken in furtherance of the statutes designed to reform health care by way of managed competition. A list of exceptions to the general rule of exemption includes certain *per se* violations of State and federal law. The Washington Attorney General is given the responsibility, together with the insurance commissioner, of periodically analyzing the market power of certified health plans under the new law.

The legislation gives the Washington Attorney General additional oversight duties. Together with the health services commission, the Attorney General monitors conduct authorized under the health care reform legislation to determine whether a more competitive alternative is practical. Both must ensure that the benefits of collaboration continue to outweigh any disadvantages resulting from a reduction in competition.

In conclusion, as a State antitrust enforcer, I strongly believe that antitrust law and principles should have an important place in the evolving American health care system. I also believe that State governments should be given primary responsibility for reconciling differences between antitrust policy and the needs of our new health care system. The States have demonstrated their capability to handle this job through the innovative legislative initiatives they have undertaken and the sensitive and public-spirited way in which State Attorneys General have enforced the antitrust laws as they apply to our health care system.

RESPONSES OF MS. COOPER TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question No. 1. State action immunity is one way for an organization to be protected from antitrust enforcement. Please give a current example of state action immunity related to health care?

Answer. A current example of state action immunity related to health care arises in the State of Maryland. The Maryland Antitrust Act, Md. Com. Law Code Ann. §11–203 (13), exempts from state antitrust law the activity of

> A hospital . . . in the course of a merger or consolidation or the joint ownership and operation of major medical equipment, to the extent that the activity is approved by the Health Resources Planning Commission under §19–123 of the Health-General Article.

Moreover, §19–123 has provided hospitals with state action immunity from federal antitrust liability since 1985 because it clearly articulates an intent to supplant "free economic competition" with the regulatory oversight of the Health Resources Planning Commission, and has resulted in actual, ongoing state supervision of the joint activity specified.

Question No. 2. Some might call the Maryland hospital payment schedule an example of 'price-fixing.' We both know that Maryland's all-payor system is protected by state action immunity. Speculate what would happen if all the hospitals in major metropolitan region decided to set prices outside of state government, that is voluntarily create their own all-payor system.

Answer. If all of the hospitals in a major metropolitan region decided to set prices outside of state government authorization and supervision, they would almost certainly be engaged in illegal price fixing in violation of state and federal antitrust laws. Under the antitrust laws competitors may not enter into agreements to set prices, a range of prices, price ceilings or specific elements of price. If hospitals were permitted to create their own, private "all-payor" system beyond public scrutiny, they would have no incentive to become more efficient or to lower prices to competitive levels. Even if the price set in this manner generally appeared to be "fair," the fixed price would likely afford the least efficient hospital a return comparable to that of the most efficient hospital. Thus, at best, consumers would continue to bear the cost of inefficient operation. At worst, hospitals could set prices at artificially high levels.

Question No. 3. Given the successful cost-containment of the Maryland all-payor system, would other regions wishing to duplicate your experience have to work through state government to avoid antitrust litigation?

Answer. If an all-payer system like Maryland's were to be adopted in other regions of the country, each region would have to set up a system of governmental review. This would be necessary not only to avoid antitrust litigation, but also to assure that the all-payer system comported with the public interest.

Maryland's experience highlights the contribution states can make to cost containment. According to the Maryland Health Services Cost Review Commission, the

state agency that sets hospital rates in Maryland, in 1992, for the seventeenth consecutive year, the cost of a hospital admission in Maryland rose 3.77%, a rate below the national average of 8.44%. In 1976, the cost of an admission in Maryland was more than 25% above the national average; in 1992, the cost per admission was 14% below the national average. The Commission believes that its success in slowing the annual increase in hospital costs is a result of hospitals responding to the incentives of the Maryland rate setting system to become more efficient. The rate setting system used in Maryland takes a quasi-public utility approach in which rates are set for each hospital department based upon reasonable costs, and are later adjusted for such items as levels of uncompensated care, inflation, volume changes and productivity. Institutions that increase productivity or otherwise lower costs are rewarded under this system.

Question No. 4. In the context of national health reform, are there any lessons you can provide from your experience in Maryland?

Answer. In our experience, most mergers, consolidations, joint ventures and other collaborative agreements occur within local health care markets. National health care reform must be flexible enough to accommodate differences among states and local markets within states. National health care reform should also acknowledge that state attorneys general have the primary and initial enforcement responsibility over local antitrust matters as well as over issues relating to compliance with state regulations in states having comprehensive health care plans.

RESPONSES OF MS. COOPER TO QUESTIONS SUBMITTED BY SENATOR HATCH

Question No. 1. A number of states have enacted antitrust waiver systems for collaborative arrangements among health care providers, primarily hospitals, without global budgets or other more regulatory systems. I realize that there has not yet been a very long record to judge the success of these systems, but any light they might shed on the national debate would be helpful.

—To the extent you can comment, what has been the experience of states like Maine, Ohio, and others which have enacted these waiver systems?
—Have costs to consumers increased or decreased?
—Has access increased or decreased?
—Have there been any noticeable differences to patients, and if so, are they more or less satisfied with the collaborative arrangements?
—Have the waiver systems proved administrable by the states and unduly burdensome on providers?
—Have the waiver systems satisfactorily alleviated the perceived antitrust risks providers face?

Answer. In 1992, Maine, Minnesota, Ohio and Wisconsin enacted antitrust legislation exempting collaborative arrangements among health care providers. In Minnesota and Ohio the exemptions are dependent upon review by state agencies that have not as yet promulgated final regulations. Without a regulatory framework, these state agencies cannot review and approve or disapprove proposed collaborations.

In Wisconsin under the Health Care Cooperative Agreements Act, the pertinent state agency was not required to promulgate regulations, nor was the agency staffed or funded. Although recently there have been numerous plans involving mergers and other forms of collaboration in Wisconsin, none of these plans has been submitted for state review. It appears that health care providers in Wisconsin are able to deal with the risk of antitrust review without invoking whatever protection the Wisconsin Hospital Collaboration Act might provide.

The Maine Hospital Cooperation Act of 1992 has been effective for nine months. During that time only one plan has been submitted for review. This does not provide sufficient information from which to determine whether the statute will have a positive impact on price, access, or patient satisfaction.

Question No. 2. How does the system compare to other systems such as those in Maryland or Minnesota which include more regulatory structures in terms of cost-savings, patient satisfaction, and provider satisfaction?

Answer. One important difference between many of the "waiver" systems and Maryland's all-payer, rate-setting system is that Maryland's system is mandatory. Under the Ohio legislation, for example, hospitals, acting through their boards of directors or boards of trustees, *may* submit a request for approval of cooperative action to the Ohio Director of Health. The Director of Health must determine whether the action is likely to reduce health care costs for consumers; improve access to health care services; or improve the quality of patient care. Further, under the Ohio law the benefits resulting from the cooperative agreement must be likely to out-

weigh the disadvantages attributable to any reduction in competition. The Attorney General then reviews the request to ensure that its implementation will not result in price-fixing or predatory pricing. An order approving the cooperative agreement provides antitrust immunity from state law. If hospitals do not submit agreements to the state for approval, they are subject to antitrust liability on the same basis as if there were no legislation. Many hospitals may choose to avoid having to file implementation plans and submitting to the jurisdiction of the Director of Health, particularly since a large number of cooperative agreements are procompetitive and would not subject the participants to antitrust liability.

Question No. 3. You mentioned the state action immunity doctrine as a way for states to shield health care providers from antitrust risk. Is it not the case that state action immunity can only be invoked as a defense in costly litigation which threatens treble damages.

—Many providers suggest to me that the risks and costs of litigation are a major concern to them, not just the possibility of eventually winning. While the state action doctrine may provide some comfort to providers, is it no rather cold comfort?

Answer. When health care providers act pursuant to clearly articulated and affirmatively expressed state policy, and their actions are actively supervised by a state agency, as the state action doctrine requires, they are unlikely to be threatened with treble damages from an antitrust lawsuit. The Supreme Court has set out guidance for those relying upon state action immunity in a number of cases within the past ten years. The most recent case, decided just one year ago, is *FTC* v. *Ticor Title Insurance Co.,* 112 S. Ct. 2169 (1992). In that case, the Court explained the basis for the dual requirements of the State action doctrine: "Both are directed at ensuring that particular anticompetitive mechanisms operate because of deliberate and intended state policy." *Id.* at 2178. The state action doctrine was adopted to foster and preserve principles of federalism. "Immunity is conferred out of respect for ongoing regulation by the State, not out of respect for the economics of price restraint." *Id.* at 2177.

In Maryland, there have been no antitrust challenges to hospital mergers, consolidations or joint activity exempted by the state legislation enacted in 1985. Even if a lawsuit were filed, state action immunity is a defense that can be raised at an early stage of the proceedings. In a state like Maryland with clearly applicable legislation, a hospital could file a motion to dismiss the action in direct response to the complaint, before discovery commences. Federal judges have exhibited a willingness to structure pre-trial proceedings to delay discovery, the most expensive aspect of antitrust litigation, if there is a credible argument, like state action, that could dispose of the case quickly and economically. Moreover, if the state action issue were clear, Rule 11 sanctions for filing a frivolous suit would be appropriate.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

Good morning Mr. Chairman. Sound markets require informed *consumer choice.* Managed competition attempts to enhance choice in two ways—by providing information and by allowing consumers to choose among health plans based on reliable price and quality information. Without informed consumers—and providers held accountable for results—we will never achieve cost containment and high quality care.

And we can't do that without a market-based price mechanism. Medical markets work best when the best providers get all the business, and smart buyers are rewarded with better service and lower prices. The key to this is a price system that works—and more and better information.

Under managed competition, consumers will choose among competing Accountable Health Plans (AHPs). Within each plan, there may be hundreds of participating providers among whom a consumer may choose. The plan administrators guarantee that the providers they have selected meet high quality standards.

In truth, choice is not threatened by this managed-competition structure of competing AHPs—rather, it is enhanced.

However, the question to be addressed is: Are there changes that could be made in the area of antitrust policy and enforcement that could serve the purpose of protecting the value of consumer choice from anticompetitive behavior, while also encouraging the health care community to make structural changes to make the system more productive?

Anticompetitive practices cost our health care system money. The most egregious examples are price-fixing, boycotts, market allocation and tying arrangements. Ten percent of our national health care expenditures are estimated to be due to anti-

competitive behavior. That amounted to $74 billion in 1991, or $790 in the average family's health bill. It is for this reason that those of us interested in reforming our nation's health care system need to become more aware of the effect antitrust laws may have on providers and providers' perception of the laws, especially as we move to establish Accountable Health Plans (AHPs). There is concern in this area that antitrust laws prohibit the creation of integrated service networks under certain circumstances, especially horizontal restraints of trade. But, there is also concern that weakening the laws could complicate the negotiating process and cause managed competition to ultimately suffer.

Many years ago, the federal government had the opportunity to support network building. In 1937, the Group Health Association of Washington, D.C. organized as a nonprofit cooperative. Basically, their arrangement resembled a group practice or HMO. However, the American Medical Association questioned their structure and sought to intervene. Ultimately, the Justice Department Indicted and convicted the AMA on charges of violating the Sherman Antitrust Act in its efforts to suppress the GHA.

The lesson that the medical community took away from this was to avoid cooperative practice arrangements. This is a classic example of a "chilling effect" that has remained with us for over fifty years.

Mr. Chairman, it is imperative we examine what the federal role should be in encouraging network building. I firmly believe that competition produces productivity, which is essential to cost-efficient, innovative care. Government should design incentives that will manage competition and prevent market failure. In short, government must act as a facilitator of the marketplace.

In this endeavor, questions regarding antitrust law are surfacing. Therefore, Congress must consider whether the current antitrust laws will continue to serve the consumers' best interests under a new health care infrastructure.

Antitrust legislation was enacted more than 100 years ago to prevent the abuse of market power. However, it is only recently that health providers were deemed subject to antitrust liability. In examining market power in health care we need to consider the climate in which medicine is practiced. Basically, two markets emerge—geographic and specialty-related.

Encouraging network building affects both market areas. In some ways it is relatively easy to define a geographical area of competition—a city or a metropolitan area. However, in many ways it is purely subjective. In rural areas—where there are physician shortages—it can be impossible.

It is clear from past decisions that collaboration to split up geographical areas for the purpose of eliminating competition is "per se" illegal. Yet in reviewing market power for a prospective merger, geographical definition becomes rather murky. So the question remains, do we need to clarify the law in any way to set forth our intention to garner a more productive system? Or, is the current practice of case-by-case review under the "rule of reason" satisfactory?

First, we should acknowledge that the federal government doesn't challenge many mergers or joint venture cases. And the Administration recognizes the need for providers to collaborate in order to achieve greater efficiency and productivity in the system.

However, in practice, there remains a "chilling" effect that discourages providers from entering joint ventures for fear of being subject to antitrust action. Congress needs to consider the problem such misperceptions reap on the goals defined in undertaking comprehensive health reform—access, quality, cost-efficiency, and productivity.

Second, the states are trying to solve the problem. We are witnessing more and more state governments' attempting to protect health care providers from antitrust liability in their own health reform efforts. Minnesota is working on legislation to guarantee state oversight efforts meet the two standards of the "state action" immunity doctrine. Last year, Minnesota specifically expressed its intent to replace competition with regulation. And currently, there is legislation pending in the Minnesota Legislature that outlines the process by which applications will be reviewed, scrutinized and supervised.

Third, there are a myriad of proposals at the federal level ranging from specifically exempting health care providers from antitrust liability or merely seeking to clarify the ambiguity surrounding the statutes of jurisdiction.

Finally, I am pleased to represent a state that is serving as a leader in health reform. We can learn a lot from service delivery in Minnesota. Today, we will hear a perspective that has been generally overlooked—that of the consumer or purchaser.

Steve Wetzell, Executive Director of the Business Health Care Action Group (BHCAG) in Minneapolis will be speaking for employers who-are striving to provide better quality care to consumers through integrated systems of care.

In addition, I would like to request that written testimony from my constituent, Ron Schiemann, Administrator of Quality Health Network, Inc. be accepted as part of the hearing record. I asked Mr. Schiemann to provide the Committee with testimony specifically addressing antitrust application to network building in rural areas. The purchaser viewpoint is especially relevant as we discuss the creation of health insurance purchasing cooperatives (HIPCs) and Accountable Health Plans (AHPs).

In theory, managed competition should allow providers to compete on the basis of quality, services and value—including price.

PREPARED STATEMENT OF JAMES C. EGAN, JR.

Mr. Chairman and members of the subcommittee: I am James C. Egan, Jr., Director for Litigation for the Federal Trade Commission's Bureau of Competition. My responsibilities include the Bureau's Health Care Division, which handles the majority of the Commission antitrust cases relating to health care. I am pleased to appear before you today to present the testimony of the Federal Trade Commission on the relationship between antitrust enforcement and health care reform.[1]

There is intense interest in proposals for containing the rapidly increasing cost of health care in the United States. I am not, of course, in a position to discuss any particular proposal;[2] but representing an agency that for years has been an advocate and defender of the role of competition in health care, I do want to discuss an element that has figured prominently in the reform discussions to date—reliance on competition in the health care field, including the development of managed care and other alternative delivery plans. First, however, I would like to begin by giving you a brief general description of the Federal Trade Commission and the antitrust laws it enforces. Then I will address the Commission's role in enforcing these antitrust standards in the health care sector of the economy.

The antitrust laws have been described by the United States Supreme Court as the "Magna Carta of our free enterprise system." These laws reflect a judgment that competition generally promotes consumer welfare and generally produces the best mix of quality goods and services at the lowest prices. The antitrust laws also assure business people an opportunity to offer their goods and services in the marketplace, and to have their success or failure determined by consumers' preferences, not by the abuse of market power of other competitors.

Section 5 of the Federal Trade Commission Act gives the Commission two basic powers: to prevent "unfair methods of competition," and to prevent "unfair or deceptive acts or practices." Only the first of these powers is the subject of my remarks today.[3] In practice, the FTC's power to prohibit unfair methods of competition means enforcing the principles contained in the federal antitrust laws—primarily the Sherman Act and the Clayton Act.

Two major concerns of the antitrust laws are conspiracy in restraint of trade, and monopolization. The Sherman Act prohibits all conspiracies or agreements that unreasonably restrain trade; not all conspiracies or agreements—just those that *unreasonably* restrain trade. The language is purposefully general and prevents businesses from engaging in a host of concerted actions that may dampen competition without any offsetting consumer benefit. As interpreted by the courts, these restraints include agreements to fix prices or to divide marketing territories or groups of customers. Also prohibited are conspiracies among competitors to boycott other firms or, under certain circumstances, to use coercive tactics with the intent and effect of injuring competition.

The essence of all these types of conspiracies is that otherwise independent businesses each agree to give up freedom to act on their own, and instead act collectively to lessen competition among themselves or to suppress competition from some firm

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[1] This written statement represents the views of the Federal Trade Commission. My oral presentation and response to questions are my own, and do not necessarily represent the views of the Commission or any individual Commissioner.

[2] The Administration's Health Care Reform Task Force is currently scheduled to announce its proposals later this month.

[3] The FTC Act authorizes the Commission to challenge "unfair or deceptive acts or practices" such as consumer fraud and false or misleading advertising. The FTC's Bureau of Consumer Protection investigates these practices.

outside the group.[4] In these cases, proving a "conspiracy" does not require production of a signed contract or videotaped secret meetings. An agreement may be inferred from circumstantial evidence if such evidence tends to exclude the possibility that alleged conspirators acted independently.

Monopolization is a second area of concern of the antitrust laws. Monopoly power is the power to raise prices or restrict output (including lowering quality) without fear of competition. Because some monopolies are a natural result of innovation or a firm's business skill at pleasing consumers, merely having monopoly power is not illegal. But obtaining a monopoly through improper conduct—"monopolization"—is illegal. A firm "monopolizes" if it engages in unfair or unreasonably exclusionary practices to obtain or keep a monopoly.

Since both monopolization and anticompetitive conspiracies are disfavored, antitrust also tries to prevent the development of market conditions that might foster them. To do this, mergers between competitors are declared illegal by the Clayton Act if their effect is likely to be a substantial lessening of competition. The competitive concern with a merger that creates a monopoly is perhaps self-evident. Where a merger stops short of creating an absolute monopoly, but nevertheless reduces the number of competitors, the concern is that "where rivals are few, firms will be able to coordinate their behavior, either by overt collusion or implicit understanding, in order to restrict output and achieve prices above competitive levels." *FTC* v. *PPG Industries, Inc.*, 798 F.2d 1500, 1503 (D.C. Cir. 1986). Thus a major concern of the Clayton Act is whether a merger will allow the remaining competitors "to coordinate their pricing without committing detectable violations . . . of the Sherman Act . . . ." *Hospital Corp. of America* v. *FTC*, 807 F.2d 1381, 1387 (7th Cir. 1986). Frequently, before-the-fact intervention is the only effective way to deal with potentially anticompetitive mergers. Once the merger has occurred, it often is difficult or impossible to "unscramble the eggs" and return a market to the pre-merger state of competition.

With this general background about the Commission's antitrust law enforcement mission, I now want to turn to the Commission's past and future roles in applying these laws in the health care sector of the economy. I have two principal points. First, antitrust enforcement by the Commission has been instrumental in enabling alternatives to traditional fee-for-service health care arrangements to enter health care markets in the face of opposition by some health care providers. Commission enforcement actions have challenged anticompetitive rules that prohibited physician affiliation with health care plans, and have halted organized boycotts by some health care providers against newly developing health care arrangements.

Second, continued sound antitrust enforcement seems likely to be important to the success of any competition-based model for health care reform. I will not suggest that any particular antitrust exemption would doom any particular health care plan. However, proposals for broad statutory antitrust exemptions that are now being advocated by some provider groups could frustrate the drive to contain rising health care costs. Experience from the Commission's health care enforcement program suggests that antitrust enforcement plays an important role in preventing organized efforts to reduce price competition and to thwart cost reductions.

The FTC enforces the antitrust laws to ensure that competitive forces will allow the development of health care delivery desired by consumers. The Commission does not favor one type of health care delivery system over another. Instead, the Commission endeavors to keep markets competitive so that firms may offer, and consumers may choose, whatever health care options they prefer. We do not advocate that consumers choose a managed care plan over a fee-for-service health care plan. Nor does the Commission take a position on which kind of health care plan provides better quality health care at lower prices. Instead, we try to level the playing field so that each plan may develop and grow as they meet the wants and needs of consumers. The Commission seeks to ensure that anticompetitive behavior does not impede or block the development of health care alternatives that consumers might elect to use. This background on the function of the Commission in enforcing the antitrust laws is a useful starting point for understanding our role in this process.

Through sound antitrust enforcement the FTC has helped allow market forces to create an environment in which innovative forms of health care delivery could emerge to compete on the merits. In that competitive environment, these alternative health care delivery systems grew as consumers were attracted by the services or

[4] The antitrust laws also apply to the relationship between a manufacturer and its distributors or customers. In this kind-of "vertical" relationship, the antitrust laws leave room for considerably more latitude, since a manufacturer obviously must have contracts and agreements with its distributors and customers.

lower prices these plans offered. The concepts that form the foundation for some of today's reform proposals were greatly facilitated by antitrust law enforcement.

Before I develop these points in greater detail, however, let me offer a general caveat. Although I firmly believe that antitrust enforcement has been and will continue to be an important factor in allowing for the development of a more cost-effective health care delivery system, antitrust cannot, and will not, alone solve the problem of controlling health care costs. My suggestion is a more modest one: that antitrust has a role to play in fostering competition in health care markets and thereby facilitating other cost containment efforts. I believe that the Federal Trade Commission can and should continue to play a significant, constructive role in this process.

I. THE CONTRIBUTION OF ANTITRUST ENFORCEMENT TO THE DEVELOPMENT OF HEALTH CARE PLANS

Understanding the role that antitrust enforcement has played during the last two decades in opening health care markets to new forms of competition requires an historical perspective. Until the late 1970s, most physicians practiced solo, fee-for-service medicine. There were few alternative arrangements. Even multispecialty group practices were rare, and health care plans that sought to compete by signing up a limited panel of selected physicians were impeded by a variety of restrictions. Most hospitals operated in a similarly independent fashion, with few limitations on what they could charge.

The early forerunners of today's managed care arrangements met with opposition. Some physicians who associated with such plans were the targets of reprisal, facing charges of unethical conduct, expulsion from local medical societies, and loss of hospital privileges.[5] In 1943, the Supreme Court upheld a criminal antitrust conviction of the American Medical Association and the Medical Society of the District of Columbia for conspiring to obstruct the operation of Group Health Association, an early health maintenance organization.[6] The associations had taken disciplinary actions against Group Health staff physicians, imposed sanctions against doctors who consulted with Group Health physicians, and threatened disciplinary action against hospitals at which Group Health doctors were permitted to practice.

Notwithstanding the Supreme Court's decision, providers of alternative health delivery systems, and physicians who associated with them, continued to face opposition to their activities. In 1975, the Commission issued an administrative complaint challenging the AMA's ethical standards. The complaint alleged that the AMA's ethical restrictions prohibited physicians from providing services to patients under a salaried contract with a "lay" hospital or Health Maintenance Organization ("HMO"), "underbidding" for a contract or agreeing to accept compensation that was "inadequate" compared to the "usual" fees in the community, and entering into arrangements whereby patients were supposedly denied a "reasonable" degree of choice among physicians. In 1979, the Commission held that all of these restraints violated the antitrust laws.[7]

HMOs and other managed care plans attempt to achieve cost-effectiveness by limiting the provider panel to those known to provide the desired quality of care, giving this limited panel incentives to control costs, and in some instances exercising direct supervision over the appropriateness of the course of treatment selected. While patient choice is limited once the patient has enrolled in such a plan, the existence of these plans allows the purchasers to decide whether the cost savings the plans offered are worth accepting their limitations. But prohibitions of "inadequate" fees or requirements of "reasonable" provider choice can impede the ability of these plans to operate effectively.

The advertising aspect of the Commission's *AMA* case also benefited consumers. Doctors had been prohibited by the AMA's ethical rules from disseminating truthful information to the public about the price, quality, or other aspects of their services (such as office hours, acceptance of Medicare assignment or credit cards, use of Spanish-speaking staff, or house-call services).[8] The Commission found that this ban on truthful advertising had a particularly adverse impact on newly emerging plans such as HMOs, which needed to advertise precisely because they were novel, and thus unfamiliar to consumers.[9] The ability to advertise is particularly important to a new market entrant.

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[5] *See* P. Feldstein, Health Associations and the Demand for Medical Care 40–44 (1977).

[6] *American Medical Ass'n* v. *United States,* 317 U.S. 519 (1943).

[7] American Medical Ass'n, 94 F.T.C. 701 (1979), *aff'd as modified,* 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court,* 455 U.S. 676 (1982).

[8] *See Id.* at 846–48. *See also* Broward County Medical Society, 99 F.T.C. 622, 624 (1982) (consent order).

[9] 94 F.T.C. at 1006.

Even after the Commission's *AMA* case freed physicians to affiliate with health care plans, these plans often continued to face boycotts by providers. While some providers join managed care plans, and many others compete against them on the merits, our experience shows that some providers have engaged in illegal concerted action to resist new forms of competition. The Commission has taken action to remedy conduct such as obstructing hospital privileges for HMO physicians[10] and boycotting a hospital that was planning to open an HMO facility.[11]

Within the last two years alone, the Commission has issued a series of orders against alleged threatened boycotts by physicians in the Fort Lauderdale, Florida, area to prevent local hospitals from pursuing affiliation with the Cleveland Clinic.[12] The Cleveland Clinic is a nationally known provider of comprehensive health care services. The Clinic, which operates as a multispecialty group medical practice, offers a predetermined "global fee" or "unit price" covering all aspects of many services, such as surgery. The Commission's complaints alleged that when the Clinic sought to establish a facility in Florida, local physicians sought to prevent its physicians from gaining hospital privileges by threatening to boycott the hospitals. Our orders prevent such activity from recurring.

The Commission also played an important role in taking enforcement action to end barriers to the emergence of independent health care prepayment plans. The first medical and hospital prepayment plans—forerunners of today's Blue Cross and Blue Shield plans—were outgrowths of state or local medical societies and hospital associations. These groups initially had direct control of the plans, but in the early 1970s the Blue Cross plans began to split off from the hospital associations. Provider control of Blue Shield plans lasted longer. An important factor in the debate about provider control of Blue Shield plans was a Commission staff report detailing evidence that medical societies had used control of the plans to increase physicians' fees and to obstruct competition from nonphysician providers and from health care plans.[13]

One of the first Blue Shield plans to become independent of a medical society was Blue Shield of Michigan. Once independent, this plan introduced several proposals to contain the rising cost of physicians' services. The state medical society responded by forming a "negotiating committee" that orchestrated boycotts of the plan to defeat cost containment. In *Michigan State Medical Society,* the Commission prohibited such joint "negotiations."[14]

The Commission has since enjoined a number of other conspiracies to obstruct cost containment measures, in cases such as *Federal Trade Commission* v. *Indiana Federation of Dentists,*[15] where the Supreme Court unanimously affirmed a Commission decision halting a conspiracy among dentists to frustrate a cost containment program by withholding dental X-rays from insurers. The refusal to provide the X-rays frustrated the cost containment effort by preventing the efficient operation of utilization control mechanisms.[16] More recently, we obtained a consent order that required the dissolution of an allegedly "sham" venture among physicians who were not economically integrated but simply operated to conduct joint negotiations to defeat the cost reduction initiatives of third-party payors.[17]

Also important to health care cost containment is the preservation of competition among institutional providers of health care services, including hospitals. Thus, our review of hospital mergers, as I will discuss later, helps to maintain competitive conditions that enable consumers and health care plans to choose among competing alternatives.

The antitrust enforcement actions I have just described by no means exhaust the categories of the Commission's efforts to preserve competition and thus expand the variety of health care plans, particularly more cost-containment options. For example, the Commission has brought cases that challenged unjustified restrictions on the delivery of health care services by nonphysician providers, such as nurse-mid-

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[10] Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) (consent order).

[11] Medical Staff of Doctors' Hospital of Prince Georges County, 110 F.T.C. 476 (1988) (consent order).

[12] Diran Seropian, M.D., Dkt. No. 9248, 57 Fed. Reg. 44,748 (1992) (consent order); Medical Staff of Holy Cross Hospital, C–3345, 56 Fed. Reg. 49,184 (1991) (consent order); Medical Staff of Broward General Medical Center, C–3344, 56 Fed. Reg. 49,184 (1991) (consent order).

[13] Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans, Staff Report to the Federal Trade Commission (1979).

[14] 101 F.T.C. 191, 296, 313–14 (1983).

[15] Federal Trade Commission v. Indiana Federation of Dentists, 476 U.S. 447 (1986).

[16] *Id.* at 461.

[17] Southbank IPA, Inc., C–3355, 57 Fed. Reg. 2913 (1992).

wives or podiatrists.[18] The Commission does not side with non-physicians against physicians, or vice versa, of course, but seeks to ensure that consumers have the opportunity to choose between them. In general, antitrust enforcement seeks to ensure that physicians and non-physician professionals are able—so far as possible—to compete on a level playing field. The resulting expanded range of choice benefits both health care plans and individual health care consumers.

The Commission has also acted against provider efforts that directly sought to frustrate cost-containment programs. The Commission has entered several consent orders with associations of pharmacies and their members that had allegedly organized boycotts to thwart third-party-payor attempts at cost containment, by jointly threatening to withdraw as providers from the payors' prescription drug benefit programs unless the pharmacies' compensation demands were met.[19]

Commission enforcement in pharmaceutical markets has not been confined to pharmacy boycotts. Last year, the Commission issued an order preventing Sandoz Pharmaceutical Corporation from "tying" its antipsychotic drug, clozapine, to a blood testing and monitoring service.[20] This action likely saved the Department of Veterans Affairs, one major purchaser of clozapine, $20 million a year.[21]

Last year, two leading manufacturers of infant formula settled Commission charges that they had engaged in unilateral facilitating practices to eliminate competitive sole-source bidding in the federal government's Women, Infants, and Children (WIC) program in Puerto Rico. The manufacturers agreed to refrain from such actions in the future and to provide restitution in the form of 3.6 million pounds of free infant formula to the U.S. Department of Agriculture, which administers the WIC program.[22]

Finally, I would be remiss if I did not mention some of the merger cases brought by the Commission in the health care area. In addition to the hospital merger cases, which I will discuss later, in the last three years the Commission has entered into consent orders restructuring transactions among firms producing such diverse health care products as dental amalgams, human growth hormone, and wheelchair lifts.[23] By preventing transactions that are likely to reduce competition and lead to higher prices in a broad spectrum of health care markets, the Commission's merger enforcement contributes to the overall health care cost containment effort.

II. ANTITRUST EXEMPTIONS AND HEALTH CARE REFORM

Just as sound antitrust enforcement has contributed significantly to the growth of alternative arrangements in the health care sector, so it is likely to be an important underpinning of future reform. Our experience in health care markets has shown that, without the protection that antitrust law provides, efforts to contain health care costs sometimes can be frustrated by the opposition of certain providers.

Nonetheless, there have recently been a variety of proposals to create special antitrust exemptions for collective action by hospitals and physicians. Some seek an exemption for mergers and various kinds of joint ventures from antitrust scrutiny. Others seek an exemption for various forms of concerted action—in particular, collective negotiations with health care purchasers and payors. Without getting into the specifics of any proposal, I want to explain the reasons for concern about exemptions in this area.

At their core, the proposed exemptions for physicians and hospitals may be based on questionable arguments about the nature of competition in health care markets

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[18] For example, the Commission prohibited boycotts of nurse midwives (State Volunteer Mutual Ins. Corp., 102 F.T.C. 1232 (1983) (consent order)) and podiatrists (North Carolina Orthopaedic Ass'n, 108 F.T.C. 116 (1986) (consent order)).

[19] *E.g.*, Southeast Colorado Pharmacal Ass'n, C–3410, 57 Fed. Reg. 52,631 (1993) (consent order); Peterson Drug Company, No. D–9227 (1992) (Commission adopted opinion of administrative law judge after appeal withdrawn); Chain Pharmacy Ass'n, No. D–9227, 56 Fed. Reg. 9223 (1991); Orange County Pharmaceutical Soc'y, No. C–3292, 55 Fed. Reg. 31,441 (1990) (consent orders).

[20] Sandoz Pharmaceutical Corp., C–3385, 57 Fed. Reg. 36,403 (1992) (consent order).

[21] This was one of two tying cases brought by the Commission. In the other case, the Commission prohibited the owner of certain renal dialysis clinics from using a tying arrangement to circumvent Medicare reimbursement limits on outpatient dialysis services. Gerald S. Friedman, No. C–3290, 55 Fed. Reg. 27,686 (1990) (consent order).

[22] FTC v. Mead Johnson & Co., No. 92–1366 (D.D.C. June 11, 1992) (consent order); FTC v. American Home Products Corp., No. 92–1365 (D.D.C. June 11, 1992) (consent order). The Commission is also pursuing allegations of price fixing against a third manufacturer which did not agree to settle the Commission's allegations. FTC v. Abbott Laboratories, 1992–2 Trade Cas. (CCH) ¶ 69,996 (D.D.C. 1992).

[23] Dentsply International, Inc., C–3407, 58 Fed. Reg. 6796 (1993) (consent order); American Stair-Glide Corp., C–3331, 56 Fed. Reg. 26,108 (1991) (consent order); Roche Holding Ltd., C–3315, 55 Fed. Reg. 53,191 (1990) (consent order).

and how antitrust law applies to physicians and hospitals. One argument is that due to market imperfections, competition in health care does not work to contain costs and ensure quality. The other argument is that antitrust law is not flexible enough to deal with markets, such as many health care markets, that may not resemble perfect competition. In our view, however, the record of antitrust enforcement in the health care field shows that competition is important to containing costs and ensuring quality, and that antitrust enforcement is flexible enough to prevent harmful conduct without interfering with efficient joint conduct that benefits consumers.

A. Hospital Exemptions

Recently, Congress has considered a number of proposals for special antitrust exemptions for hospital mergers and joint ventures. Certain groups have proposed legislation that would allow hospitals, under some circumstances, to obtain antitrust immunity for combining their operations, or sharing medical services or equipment.

Is there a need for this type of legislation? The proponents pose two arguments. First, they contend that due to widely perceived uncertainty about the antitrust laws' prohibitions, efficient mergers and joint ventures among hospitals are prevented or inhibited. Second, and more broadly, they contend that there is an inherent conflict between the antitrust laws and demands to contain costs by eliminating unnecessary duplication of services and facilities. We believe that the available evidence fails to support their assertions.

Sound antitrust enforcement does not hinder efficient, procompetitive collaborations. Let me put the issue in perspective. In a typical year, there are about 50 to 100 hospital mergers or other arrangements consolidating previously independent hospitals. Review of these transactions by Commission staff normally entails minimal or no direct contact with the parties and no delay in the transaction beyond statutory Hart-Scott-Rodino requirements. In the past decade, the Commission has conducted only about two dozen formal investigations, mostly involving larger metropolitan hospitals, and has challenged, on average, less than one hospital merger a year.

Our assessment of the impact of antitrust enforcement on hospital collaborations has been confirmed by some others. Hospital merger and joint venture activity has been so vigorous that a recent article in *Modern Healthcare* was entitled "Mergers Thrive Despite Wailing About Adversity."[24] After an examination of the record, the article dismissed the claim that antitrust enforcement inhibited hospital consolidation. Similarly, a Department of Health and Human Services task force recently examined the claim that enforcement agencies have become too adversarial in challenging hospital mergers, concluding that the assertion was not supported by the evidence.[25]

The HHS task force specifically addressed the issue of rural hospital mergers, which has been the subject of some attention of late. It found that there was no evidence that the possibility of scrutiny by the antitrust enforcement agencies adversely affected consolidation among hospitals in rural markets. The task force also found that very few such mergers are investigated, and concluded that there was "no need to exempt and therefore tacitly encourage mergers among hospitals in rural or 'small' urban settings."[26] We believe that the task force report supports our contention that antitrust enforcement does not inhibit efficient mergers in the hospital area.

The enforcement record on hospital joint ventures similarly should not evoke concern. To date, the Commission has not challenged a single joint venture among hospitals. Indeed, in the context of our merger enforcement, we have expressly allowed various types of hospital joint ventures that are not likely to raise serious antitrust concerns. In a recent order blocking a hospital merger in a highly concentrated market, the Commission exempted from the order's reporting requirements any prospective joint ventures the hospitals might decide to undertake to provide data processing, laboratory testing, and health care financing.[27] These joint ventures appeared

[24] *Modern Healthcare,* Oct. 12, 1992, at 30.

[25] *Report of the Secretary's Task Force on Hospital Mergers,* at 11 (Jan. 1993). The report noted that between 1987 and 1991 the FTC and the Justice Department investigated only 27 of 229 hospital mergers and challenged only 5 transactions.

[26] *Id.* at 9.

[27] University Health, Inc., FTC Docket No. 9246, 57 Fed. Reg. 29,084, 44,748 (1992) (consent order) (exempting a wide range of support service joint ventures). *See* Federal Trade Commission v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991) (upholding FTC challenge to acquisition of hospital). *See also* The Reading Hospital, FTC Docket No. C–3284, 55 Fed. Reg. 3264, 3266, 15,290 (1990) (consent order) (the Commission determined that voluntary separation

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likely to achieve efficiencies and improve specific services, without endangering price and quality competition for other competitive services, as a complete merger could.

The great majority of hospital mergers and joint ventures—like those in most lines of business—do not endanger competition. Host hospital mergers do not pose a threat to competition because they occur in markets with a substantial number of competitors. Indeed, many hospital mergers may enhance efficiency and promote competition.

Similarly, many hospital joint ventures are efficiency-enhancing. Joint ventures can make new technologies available to communities that otherwise could not have them and can spread the cost of ownership of expensive equipment among competing providers. But joint ventures need not be confined to the acquisition of expensive technologies. They may also facilitate the provision of essential services to a community. Thus, it may not be surprising that most hospitals engage in some forms of joint venture activity. To cite but one example, virtually all hospitals acquire many of their day-to-day supplies through buying cooperatives.[28]

But the fact that most hospital mergers and joint ventures are procompetitive does not mean that there is no place for antitrust enforcement in hospital markets. Some transactions involving hospitals are anticompetitive, and the Commission seeks to ensure that health care consumers have a sufficient selection of competing providers to be able to shop for the best possible bargain.

In our hospital merger investigations, we examine a broad range of evidence concerning the likely impact of the merger on health care costs. We do not rely on market concentration figures standing alone. One of several factors to be examined is the views of buyers of hospital services including insurance companies, health care plans, and large employers. In many of these investigations, these buyers have stated that competition among hospitals is important because it permits them to get better deals. When we review hospital mergers, we consider whether the merger will help or hurt payors and health care plans in their attempts to hold down cost increases. If hospital mergers are exempted from the antitrust laws, hospitals may be able to acquire market power and resist such cost-containment efforts.

Finally, let me address the argument that merger enforcement in the health care area actually leads to higher, not lower health care costs. The argument we hear with increasing frequency is that competition among hospitals should not be encouraged because it leads to costly duplication of services and facilities. This argument was made to the Commission by Hospital Corporation of America in defense of a proposed merger a few years ago. The Commission found that the argument was contradicted by a great deal of evidence in that case, including internal hospital documents stating that "increasing competition in the health care sector . . . will allow natural market forces to slow the price spiral."[29]

The Commission's experience in merger enforcement in the health care area has demonstrated that often procompetitive mergers can result in the elimination of duplication of services. In some circumstances, elimination of redundant underutilized facilities can improve the effectiveness of operating those that remain. The Commission is aware, however, that care must be given to ensure that eliminating duplication of services does not become simply a convenient excuse for avoiding competition.

B. Exemptions for Professionals

Current proposals for an antitrust exemption for physicians focus on physicians' dealings with purchasers and payors of health care services. Today many physicians compete to be selected by one or more health care plans. Through this competition among physicians, plans seek to employ enough quality physicians without paying unnecessarily high prices. One exemption supported by certain health care professionals would permit competing physicians to eliminate competition by joining together and, without engaging in any risk sharing or integration of their practices or finances, collectively bargaining with large purchasers and payors of health care services.

Purchasers and payors that represent a large number of consumers may have sufficient clout and knowledge to bargain aggressively with physicians and other health care providers to obtain lower charges and adherence to a variety of cost-contain-

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of the merged hospitals was sufficient to restore them as independent competitors, even though both hospitals continued to participate in hospital-sponsored health plan joint ventures, and to share laundry, laboratory and biomedical equipment repair services).

[28] *See Nearly All Hospitals Use Group Purchasing,* Modern Healthcare, Dec. 24–31, 1990, at 40.

[29] Hospital Corp. of America, 106 F.T.C. 361, 478–87 (1985), *aff'd,* 807 F.2d 1381 (7th Cir. 1986), *cert. denied,* 481 U.S. 1038 (1987).

ment measures. An exemption allowing sellers of health care services to aggregate for bargaining purposes may, however, enable providers to defeat legitimate cost containment efforts.

The argument for exempting health care providers' joint bargaining from antitrust scrutiny is based on the questionable premise that health care purchasers possess market power and can therefore artificially depress health care prices. In most markets, however, there appear to be a large number of medical care alternatives, including Blue Cross and Blue Shield plans, numerous commercial insurers, HMOs, and other firms that offer health insurance or benefits. In the absence of market power on the part of large purchasers and payors, permitting physicians to aggregate their power would not create a "counterbalance," but rather could give physicians unconstrained market power and the ability to raise prices for health care services. Even in circumstances in which the number of payors is limited, we are not aware of any evidence to suggest that allowing physicians to collaborate in negotiating prices will lead to any benefits to consumers.

But we need not rely on theories to see what happens when provider groups collectively "negotiate" with payors and purchasers. A good example is the *Michigan State Medical Society* case I mentioned. To satisfy consumers, the plan needed to have contracts with a large enough number of physicians who would agree to accept the plan's payment as payment in full. The plan relied on competition among physicians to obtain the right number and mix of physicians, but physicians agreed among themselves that they would not compete over the terms they would accept from Blue Shield. Instead, these physicians agreed that none of them would join the plan unless and until the plan responded to the demands of the medical society.

No antitrust exemption is necessary for physicians to serve, individually and collectively, as forceful advocates for their patients and profession; that is clearly legal under the antitrust laws. But as the Commission and court decisions make clear, the collective judgment of health care providers concerning what patients should want can differ markedly from what patients themselves are asking for in the marketplace. The point is straightforward. Physicians can engage in forceful advocacy and provide information to health plans without an antitrust exemption.[30] The Commission has made clear in its remedial orders governing physician boycotts that physicians may nonetheless jointly provide information to payors (or insurers).[31] But an antitrust exemption for "collective negotiations" could permit providers to override consumer choice and harm our economy.

Lately we have also heard the claim that antitrust enforcement interferes with responsible self-regulation by groups of health care providers, and that antitrust prevents such groups from addressing problems of fraud and abuse. Let me assure you that this simply is not the case. Antitrust law does not prevent professional associations from disciplining or expelling members who do not meet minimal quality of care standards, or who engage in false, deceptive, or other abusive behavior. Many Commission orders involving health care professionals contain provisions explicitly permitting the regulation of false and deceptive dissemination of information.[32] As the Commission emphasized in its 1979 opinion in the *AMA* case, professional associations "have a valuable and unique role to play" regarding deceptive and oppressive conduct by their members.[33]

Before leaving the subject of self-regulation, let me also say a brief word about the AMA's request for an FTC advisory opinion on peer review of doctor's fees by medical societies, because I have heard several public references to it recently. More than a decade ago the Commission approved the concept of advisory fee review by professional organizations.[34] Such programs can provide valuable information to pa-

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[30] The Commission's Analysis of Proposed Consent Order to Aid Public Comment in the *Chain Pharmacy Association* matter illustrates this distinction. Chain Pharmacy Ass'n of New York State, Inc., Dkt. No. 9227, 56 Fed. Reg. 12,534, 12,541 (1991).

[31] *See, e.g.*, Southbank IPA, Inc., C–3355, 56 Fed. Reg. 50912, 50914 (1991); 57 Fed. Reg. 2913 (1992); Rochester Anesthesiologists (formerly Jose F. Calimlim, M.D.), 110 F.T.C. 175, 180–81 (1988) (consent order); Michigan State Medical Society, 101 F.T.C. 191, 307–08, 314 (1983).

[32] *See* American Psychological Ass'n, C–3406, 58 Fed. Reg. 557 (1993) (Commissioner Azcuenaga concurred in part and dissented in part); National Association of Social Workers, C–3416, 57 Fed. Reg. 61,424 (1992) (Commissioner Starek dissented).

[33] American Medical Ass'n, 94 F.T.C. at 1029.

[34] Iowa Dental Ass'n, 99 F.T.C. 648 (1982) (advisory opinion approving proposal of dental association to institute a peer review program which would aid the cost containment efforts of third-party payers, so long as the fee review program was voluntary and non-binding, guidance in particular disputes was not disseminated to members generally as an indication of appropriate pricing, and the judgments of the peer review panel did not proceed from pre-agreed price standards).

tients and others who pay for medical care, and, as long as they are properly structured, present no antitrust concerns. The AMA has asked the Commission to approve a type of fee review that goes beyond the kind of peer review that has been approved in the past, because it would involve not only the provision of information to consumers about the reasonableness of specific fees, but also possible disciplinary action against physicians in certain circumstances.

In order to analyze the AMA's proposal, several months ago the Commission's staff that has been reviewing the proposal asked the AMA to provide additional information and to clarify certain aspects of the proposal. That information has been received, and the FTC staff and AMA representatives conferred in late February. The Commission intends to resolve the matter expeditiously.

CONCLUSION

Thank the Committee for the opportunity to present this testimony. I will now be happy to answer your questions.

Attachment.

I. Questions from Senator Rockefeller

1) **Are there any segments of the health care economy where immunity from antitrust violations would increase the efficiency and quality of health care?**

Answer:

I do not believe so. Antitrust law is designed to promote efficiency (including efficiencies of improved service quality), and antitrust analysis explicitly takes into account likely efficiencies. I do not know of a single instance where the antitrust laws have prevented conduct that, on balance, would have increased the efficiency and quality of health care to the benefit of consumers.

2) **Industry-specific antitrust exceptions have been made. What has been the statutory criteria for these exceptions?**

Answer:

There do not appear to be any generally applicable statutory criteria for granting an industry-specific antitrust exemption. In many, but not all cases, statutory exemptions from the antitrust laws have been granted to industries that are extensively regulated by federal or state government.

2A) **From your experience, is there any situation in which a sector of the health care economy meets the criteria for antitrust exception?**

Answer:

No. To the extent that extensive regulation by other agencies may be considered a "criterion" for exemption of certain industries, health care entities are generally not subject to comparably extensive regulation of their marketplace behavior. Consequently, exempting them from the antitrust laws, without imposing extensive regulating, could effectively permit private parties, such as hospitals, to jointly decide issues of price and quality in a manner that imperils consumers' interest in cost-effective and high quality care.

3) **Is there any research that supports advantages of competition for the hospital sector? Is the situation different in rural areas?**

Are there any circumstances where competition impedes a hospital's ability to provide high quality, cost-effective health care?

Answer:

There are a number of economic studies concluding that hospital competition is beneficial to consumers, particularly in markets where "managed care" health plans (such as health maintenance organizations) are able to take advantage of such competition to direct patients to providers offering the most

cost-effective care.[1] Those studies do not specifically address themselves to the benefits of competition in rural areas, where "managed care" plans are less prevalent. I nevertheless believe the results of the studies on hospital competition in urban health care markets can be extended to also indicate similar benefits in rural markets.[2]

Competition tends to promote, not hinder, the delivery of high-quality, cost-effective health care. This will be increasingly true as health care reimbursement mechanisms change

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[1] See Testimony of Michael A. Morrisey, Ph.D., before the Subcommittee on Investment, Jobs and Prices, Joint Economic Committee, U.S. Congress (June 17, 1992), discussing, e.g., G. Melnick, J. Zwanziger, A. Bamezai, and R. Pattison, "The Effects of Market Structure and Bargaining Position on Hospital Prices," 11 Journal of Health Economics 217 (1992); J. Robinson, "HMO Market Penetration and Hospital Cost Inflation in California," Journal of the American Medical Association (Nov. 20, 1991); J. Zwanziger and G. Melnick, "The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California," 7 Journal of Health Economics 301 (1988). See also D. Dranove, M. Shanley and W. White, "Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payor-Driven Competition," ___ Journal of Law and Economics ___ (1993) (forthcoming); J. Robinson and C. Phibbs, "An Evaluation of Medicaid Selective Contracting in California," 8 Journal of Health Economics 437 (1989); M. Noether, "Competition Among Hospitals," 7 Journal of Health Economics 259 (1988).

Some studies suggest that more competitive hospital markets have higher prices than markets with one or few providers. I believe these studies are unpersuasive. That view was shared by Judge Richard Posner of the Seventh Circuit Court of Appeals, a noted scholar in antitrust law and economics, in an opinion finding neither the "early and inconclusive" evidence on competition and pricing in hospital markets, nor the unusual characteristics of those markets (some of which facilitate rather than hinder anticompetitive price increases), justified departure from the normal legal and economic presumption that competition benefits consumers. United States v. Rockford Memorial Corp., 898 F.2d 1278 (7th Cir.), cert. denied, 498 U.S. 920 (1990).

[2] Zwanziger and Melnick attempted to measure whether rural location was a significant factor in explaining hospital costs, but their rural variable was not a significant factor. J. Zwanziger and G. Melnick, "The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California," 7 Journal of Health Economics 301 (1988).

to give hospitals greater incentives to be cost-effective (as has already occurred with the flat reimbursement rates for operating expenses under Medicare). I view the "medical arms race" scenario as aberrant and increasingly uncommon, simply because price competition and reimbursement reforms are increasingly limiting hospitals' opportunities to have wasteful expenditures subsidized by third-party payers.[3] It appears more typical for hospitals to have problems getting enough reimbursement to cover reasonably efficient operations; such hospitals would have little or no money left over to spend in unproductive duplication of functions already being performed well by other hospitals in their areas.

4) **We've heard much about the virtues of competition in health reform to bring down physician costs. Can you provide any empirical evidence demonstrating the advantages of competing physician groups?**

Answer:

Competition among physician groups takes many forms, including affiliation with managed care arrangements such as HMOs and PPO programs. Much of this competition focuses on the physicians' efficacy in controlling health care costs, including not only the costs of physician services but, perhaps of even greater import, the costs incurred through use of expensive hospital services by those physicians on behalf of their patients. A summary of the results of empirical studies concerning the effects of health care competition involving HMOs and PPOs will be part of a forthcoming article by two staff members of the Commission's Bureau of Economics.[4] I am enclosing a copy of the relevant parts of that draft article for your review.

In addition, our discussions with third-party payors in the course of numerous investigations confirm that, as a practical matter, the existence of provider competition in a market is a

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[3] Of course, not all competition by hospitals to make capital expenditures need be for wasteful expenditures. Hospitals may raise quality to attract physicians. See, D. Dranove, M. Shanley and C. Simon, "Is Hospital Competition Wasteful?" 23 Rand Journal of Economics, 247-262 (1992).

[4] P. Pautler and M. Vita, "Hospital Market Structure, Hospital Competition, and Consumer Welfare: What Can the Evidence Tell Us?," 10 Journal of Contemporary Health Law and Policy ___ (1994) (forthcoming).

necessary precondition to payors' ability effectively to negotiate with health care providers contractual arrangements that help control or lower costs to consumers. An example of the workings and effects of such competition can be found in the Minneapolis-St. Paul area, where for years there has been aggressive and widespread competition among groups of health care providers through affiliation with various competing HMOs. I think that the Minneapolis experience, among others, strongly suggests that competition can be highly successful in helping to keep health care costs lower without jeopardizing quality or access to care.

5) **The difference between actual risk and perceived risk of antitrust litigation is fairly significant. What has the FTC done to clarify to health care providers the actual risk of violating antitrust laws? What more can you do since there is a very real perception by hospitals, in my own state, that they cannot even sit in the same room together and discuss their community's health care needs?**

Answer:

The Commission regularly engages in a number of activities, both formal and informal, to explain whether any given activity is likely to run afoul of the antitrust laws. Such activities range from issuing opinions in formal adjudications in which the Commission expressly examines certain conduct and makes a determination as to its legality, through the issuance of guidelines, to giving testimony and speeches covering particular enforcement areas. Many of these activities involve generic issues of antitrust enforcement that apply generally to all industries. Other activities are focused on issues specifically related to health care.

In the area of merger enforcement, the American Hospital Association has noted that "[t]he general analytic framework for analyzing the antitrust ramifications of hospital mergers is well established."[5] The Commission and the Antitrust Division of the Department of Justice have published Merger Guidelines that outline the current enforcement policy of the Agencies.[6] These

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[5] American Hospital Association, Hospital Mergers: An Executive's Guide through the Antitrust Thicket, at p. 20 (September 1989).

[6] The Department of Justice and Federal Trade Commission Horizontal Merger Guidelines (1992), reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13,104 ("Merger Guidelines").

Merger Guidelines set forth the basic antitrust framework for analyzing mergers, including hospital mergers. Moreover, the Commission has issued opinions in two adjudicated hospital merger cases in which the Commission challenged hospital acquisitions. In each case the Commission found that the acquisitions violated the antitrust laws. The decisions set forth the Commission's reasoning in detail. In three other hospital merger cases, the Commission issued a complaint alleging that the acquisition violated the law, and accepted a consent order against the respondent.[7] Although such complaints and consent orders do not contain the same detail as adjudicated cases, they do set forth the basis of the Commission's actions.

With respect to horizontal agreements[9] among health care providers, the Commission has issued numerous decisions, has accepted numerous consent orders, and has issued advisory opinions concerning the legality of proposed conduct. The Commission's statements have covered many different horizontal activities including such issues as (1) advertising restraints

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[7] American Medical International, Inc., 104 F.T.C. 1 (1984) (order modified 104 F.T.C. 617 (1984) and 107 F.T.C. 310 (1986)), and Hospital Corporation of America, 106 F.T.C. 361 (1985), aff'd 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987).

[8] Hospital Corporation of America, 106 F.T.C. 298 (1985) (consent order) (modified 106 F.T.C. 609 (1985)); The Reading Hospital, C-3284 (FTC Consent order issued April 20, 1990, 55 Fed. Reg. 15,290 (April 23, 1990)); and University Health, Inc., D. 9246 (consent order issued September 9, 1992). In the latter case, the Commission previously obtained an injunction prohibiting the transaction pending the agency's administrative adjudication of the complaint. The court of appeals decision in particular provides detailed guidance on the application of the Clayton Act to hospital mergers. FTC v. University Health, Inc., 1991-1 Trade Cases ¶ 69,400 (S.D. Ga.) and 1991-1 Trade Cases ¶ 69,444 (S.D. Ga.), rev'd, 938 F.2d 1206 (11th Cir. 1991).

[9] Horizontal agreements refer to agreements between two firms or entities that compete with one another, as distinguished from vertical agreements that refer to agreements between a supplier and a buyer.

imposed by professional associations,[10] (2) pricing conspiracies,[11] (3) conspiracies to obstruct insurers' cost

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[10] See American Dental Association, 94 F.T.C. 403 (1979) (consent order) (modified 100 F.T.C. 448 (1982) and 101 F.T.C. 34 (1983)); American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982) (order modified 99 F.T.C. 440 (1982), 100 F.T.C. 572 (1982), and 56 Fed. Reg. 56,223 (November 1, 1991)); Broward County Medical Association, 99 F.T.C. 622 (1982) (consent order); Iowa Dental Association, 99 F.T.C. 648 (1982) (advisory opinion); Association of Independent Dentists, 100 F.T.C. 518 (1982) (consent order); American Academy of Ophthalmology, 101 F.T.C. 1018 (1983) (advisory opinion); Michigan Association of Osteopathic Physicians & Surgeons, 102 F.T.C. 1092 (1983) (consent order); Washington D.C. Dermatological Society, 102 F.T.C. 1292 (1983) (consent order); Michigan Optometric Association, 106 F.T.C. 342 (1985) (consent order); Oklahoma Optometric Association, 106 F.T.C. 556 (1985) (consent order); American Academy of Optometry, Inc., 108 F.T.C. 25 (1986) (consent order); Tarrant County Medical Society, 110 F.T.C. 119 (1987) (consent order); Connecticut Chiropractic Association, C-3351, 56 Fed. Reg. 65,093 (December 13, 1991) (consent order issued November 19, 1991); American Psychological Association, C-3406, 58 Fed. Reg. 557 (Jan. 5, 1993) (consent order issued December 16, 1992); National Association of Social Workers, C-3416, 58 Fed. Reg. 17411 (April 2, 1993) (consent order issued March 3, 1993).

[11] See American College of Obstetricians & Gynecologists, 88 F.T.C. 955 (1976) (consent order) (modified 104 F.T.C. 524 (1984)); American Academy of Orthopaedic Surgeons, 88 F.T.C. 968 (1976) (consent order) (modified 105 F.T.C. 248 (1985)); American College of Radiology, 89 F.T.C. 144 (1977) (consent order) (modified June 12, 1990, 55 Fed. Reg. 23,981 (June 13, 1990)); Minnesota Medical Association, 90 F.T.C. 337 (1977) (consent order); California Medical Association, 93 F.T.C. 519 (1979) (consent order) (modified 105 F.T.C. 277 (1985)); American Society of Internal Medicine, 105 F.T.C. 505 (1985) (advisory opinion); Preferred Physicians, Inc., 110 F.T.C. 157 (1988) (consent order); Southbank IPA, Inc., C-3355, 57 Fed. Reg. 2913 (January 24, 1992) (consent order issued December 20, 1991); American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982) (order modified 99 F.T.C. 440 (1982), 100 F.T.C. 572 (1982), and 56 Fed. Reg. 56,223 (November 1, 1991); Iowa Dental Association, 99 F.T.C. 648 (1982) (advisory opinion); Association of Independent Dentists, 100 F.T.C. 518 (1982) (consent order); Michigan State Medical Society, 101

(continued...)

containment,[12] and (4) conspiracies to restrain innovation and new entry.[13]

The Commission has also addressed restraints in health care markets that fall outside the rubric of horizontal agreements.

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[11](...continued)
F.T.C. 191 (1983); Oklahoma Optometric Association, 106 F.T.C. 556 (1985) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order); New York State Chiropractic Association, 111 F.T.C. 331 (1988) (consent order); Patrick S. O'Halloran, M.D., 111 F.T.C. 35 (1988) (consent order); Robert Fojo, M.D., C-3373, 57 Fed. Reg. 9258 (March 17, 1992) (consent order issued March 2, 1992); Debes Corporation, C-3390, 57 Fed. Reg. 39,205 (August 28, 1992) (consent order issued August 4, 1992).

[12] See Indiana Federation of Dentists, 101 F.T.C. 57 (1983), rev'd, 745 F.2d. 1124 (7th Cir. 1984), rev'd, 476 U.S. 447 (1986); Michigan State Medical Society, 101 F.T.C. 191 (1983); Indiana Dental Association, 93 F.T.C. 392 (1979) (consent order); Texas Dental Association, 100 F.T.C. 536 (1982) (consent order); New York State Chiropractic Association, 111 F.T.C. 331 (1988) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order) (consent order); Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) (consent order); Southbank IPA, Inc., C-3355, 57 Fed. Reg. 2913, (January 24, 1992) (consent order issued December 20, 1991).

[13] State Volunteer Mutual Insurance Corp., 102 F.T.C. 1232 (1983) (consent order); Health Care Management Corp., 107 F.T.C. 285 (1986) (consent order); North Carolina Orthopaedic Association, 108 F.T.C. 116 (1986) (consent order); Medical Staff of Memorial Medical Center, 110 F.T.C. 541 (1988) (consent order); Sherman A. Hope, M.D., 98 F.T.C. 58 (1981) (consent order); American Academy of Ophthalmology, 101 F.T.C. 1018 (1983) (advisory opinion); Medical Staff of John C. Lincoln Hospital & Health Center, 106 F.T.C. 291 (1985) (consent order); Physicians of Meadville, 109 F.T.C. 61 (1987) (consent order); Robert E. Harvey, M.D., 111 F.T.C. 57 (1988) (consent order); Certain Sioux Falls Obstetricians, 111 F.T.C. 122 (1988) (consent order); Lee M. Mabee, M.D., 112 F.T.C. 517 (1989) (consent order); Medical Staff of Dickinson County Memorial Hospital, 112 F.T.C. 33 (1989) (consent order); Medical Staff of Holy Cross Hospital, C-3345, 56 Fed. Reg. 49,184 (September 27, 1991) (consent order issued September 10, 1991); Medical Staff of Broward General Medical Center, C-3344, 56 Fed. Reg. 49,184 (September 27, 1991) (consent order issued September 10, 1991).

For example, the Commission has addressed the issue of exclusive contracts between hospitals and anesthesiologists.[14]

Commission members and staff have given speeches covering the wide range of substantive antitrust issues related to health care. Such speeches often provide an overview or summary of the Commission enforcement efforts in the health care area. Groups that are interested in finding out the Commission's enforcement practices have regularly invited Commissioners or staff to make presentations. Prepared remarks from such presentations are often made available to the public.[15]

Finally, to the extent that there are concerns that future conduct may carry with it potential antitrust liability, we suggest that parties simply ask the Commission staff about the conduct before engaging in it. This can be (and has been) done informally by simply discussing the proposed conduct with staff, or more formally by seeking an advisory opinion from the staff or Commission. The Commission has issued several advisory opinions

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[14] See Burnham Hospital, 101 F.T.C. 991 (1983) (advisory opinion). See also Brief of the United States and Federal Trade Commission as Amicus Curiae on Petition for a Writ of Certiorari, Jefferson Parish Hospital District No. 2 v. Hyde, 466 U.S. 2 (1984).

[15] See, e.g., "Antitrust and Managed Competition for Health Care," Remarks of Dennis A. Yao, Commissioner, Federal Trade Commission, Before the Los Angeles County Bar Association (April 16, 1993); "The Role of Antitrust Enforcement in Health Care Reform," Remarks by Janet D. Steiger, Chairman, Federal Trade Commission, Before the National Health Lawyers Association (February 19, 1993); "The Myths and Realities of Antitrust Enforcement in the Hospital Industry," Remarks by Mark J. Horoschak, Assistant Director, Bureau of Competition, Federal Trade Commission, Before the National Council of Community Hospitals (November 13, 1992); "Reflections on the Evolution of Health Care Antitrust," Remarks by Kevin J. Arquit, Director, Bureau of Competition, Federal Trade Commission, Before the New England Antitrust Conference (November 7, 1992); "The Undervalued Role of Antitrust in Meeting the Increasing Demand for Controlling Health Care Costs," Remarks by Roscoe B. Starek, III, Commissioner, Federal Trade Commission, Before the 26th Annual Antitrust Institute Program on "Current Health Care Antitrust Issues" (November 6, 1992); "The Role of Antitrust in Improving and Reforming the Health Care System," Remarks by Kevin J. Arquit, Director, Bureau of Competition, Federal Trade Commission, Before the American Bar Association, Section of Antitrust Law and Health Law Forum (October 15, 1992).

covering health care issues.[16] The American Hospital Association has stated that the Commission's advisory opinion process "often provides a relatively clear signal as to whether the Commission would challenge . . . [a particular merger] if the parties moved forward."[17]

You note in your question that hospitals in your state have a perception that they cannot meet and discuss their community's health care needs. Whether hospitals can meet and discuss their community's health needs depends upon the subjects they will discuss at such a meeting. If the subject matters the hospitals wish to discuss do not involve any competitive issues, for example a matter purely related to public health such as an exchange of medical information on certain treatments of hospitalized patients, then there is no antitrust issue at all and the hospitals are free to meet without fear of antitrust liability.

Discussions of some matters by competing hospitals do raise competitive concerns and possible antitrust liability, depending upon exactly what is discussed. Discussing conduct that is a per se violation of the antitrust laws, such as jointly raising or fixing prices, would likely expose the hospitals to antitrust liability. Discussing joint conduct such as the formation of a joint venture to offer some service none of the hospitals can efficiently offer alone is very unlikely to expose them to antitrust liability. Having legal counsel attend such meetings of competitors is often an excellent way to insure that such meetings do not stray into prohibited topics.

6. **What antitrust concerns do you have with some major health reform initiatives, such as the community care networks?**

Answer:

Most health reform proposals do not have significant antitrust implications. Either the proposals rely upon competitive markets the antitrust laws seek to preserve, or the proposals explicitly supplant market forces with government regulation. Either way, they do not offer competing health

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[16] See, e.g., Iowa Dental Association, 99 F.T.C. 648 (1982) (advisory opinion); American Academy of Ophthalmology, 101 F.T.C. 1018 (1983) (advisory opinion); Burnham Hospital, 101 F.T.C. 991 (1983) (advisory opinion).

[17] American Hospital Association, An Executive's Guide through the Antitrust Thicket, at 9-10 (April 1989).

providers significant opportunities to exploit consumers by suppressing competition.

A concern exists that such opportunities might arise under the "community care networks" model espoused by the American Hospital Association — That concern is as tentative as the AHA's proposal, which at this time is too vague for me to offer more than general observations. I understand that the AHA envisions extensive cooperation among network providers, not only to coordinate the care of network patients but also to reduce duplication of functions and facilities. The result of such cooperation might be beneficial to consumers, depending in part on local market conditions (such as the presence of competing "community care networks" to which patients can turn, or enough non-network providers to which patients or their health plans can turn, if a particular network's cooperative efforts turn out badly). But there is also the potential for such cooperation to frustrate competing visions of health care reform, by reducing the options available to non-"community care network" health plans relying upon competition among providers (for example, through competitive bidding) to reduce their costs. A dominant "community care network" might also be able to insulate itself from competition from other health plans, and thus from the market pressures that spur providers to serve consumers.

However, it is conceivable that the "community care network" concept can be effectively implemented without cooperation among competitors that may raise antitrust concerns. For example, a health plan might be able to create such a network through multiple contracts with providers, whose activities would be coordinated in cooperation with (and under the direction of) the health plan rather than with each other. Or a "community care network" might operate in a manner similar to existing highly integrated health maintenance organizations, such as the Kaiser and Group Health Cooperative systems on the West Coast, which have operated successfully for many years without antitrust problems.

7) **You are aware of the concerns of health care providers about antitrust. Are any of these concerns valid or do you think that the conduct referred to is already permissible? Can you give examples?**

Answer:

We believe that the concerns expressed by many health care providers about antitrust risks are overstated. The law enforcement records of the Federal Trade Commission and the Antitrust Division of the Department of Justice make clear that

legitimate, procompetitive arrangements by health care providers have not been subject to antitrust challenge. Moreover, both the FTC and the Department of Justice, through speeches, advisory opinions, informal consultations, and other means, continue to devote a very substantial amount of time, effort, and resources to educating and informing the public and participants in the health care sector of the agencies' enforcement intentions and antitrust law standards.

Antitrust challenges typically occur when providers act collectively not to be more efficient or not to offer something new or better to consumers in the marketplace, but to eliminate competition or engage in conduct aimed at raising prices to consumers or restricting consumers' choice. For example, such conduct has occurred when competing providers get together to prevent the entry into a market by new and competing forms of practice that consumers may prefer;[18] or where providers collectively and coercively try to extract more favorable terms (e.g., higher prices) than the providers could obtain (and consumers and third-party payors otherwise would be willing to offer) for their services if they continued to act as independent competitors.[19] When competing health care providers engage in this type of anticompetitive conduct, consumers are offered less choice at higher prices. In such circumstances, providers justifiably should be concerned about being subject to antitrust law enforcement activity.

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[18] See, e.g., Medical Staff of Broward General Medical Center, C-3344, 56 Fed Reg. 49,184 (September 27, 1991) (consent order issued September 10, 1991). The complaint alleged that physicians and other health practitioners with privileges to practice at a Ft. Lauderdale, Florida, hospital conspired to prevent a new, multi-specialty group practice, the Cleveland Clinic, from entering their market.

[19] See, e.g., Southbank IPA, Inc., C-3355, 57 Fed. Reg. 2913 (January 24, 1992) (consent order issued December 20, 1991). The complaint alleged that twenty three obstetrician/ gynecologists in Jacksonville, Florida, agreed to fix the fees that they charged to third-party payors.

II. Questions from Senator Durenberger

1) **A major element of health systems reform is restructuring the way that health care is delivered. Many group practices in Minnesota, such as the Mayo Clinic, the Olmstead Medical Group and the Park Nicollet Medical Center are already moving ahead to capture the efficiencies and improved quality that comes from organizing the delivery of health care.**

What are the antitrust implications of organized delivery systems or integrated delivery systems negotiating with health alliances? How does the FTC interpretation of collective negotiations apply to organized delivery systems? Large multispecialty group practices?

Answer:

Health care providers who join together in organized delivery systems or integrated delivery systems often are able to offer more or better choices than they could provide independently. Examples of such integrated groups include group medical practices, staff model HMOs, and risk bearing IPAs. Antitrust law recognizes that, in the absence of market power, such integrated practices are likely to be pro-competitive. Thus, joint negotiations that are ancillary to an integrated practice usually bear no antitrust risk. Indeed, a high percentage of the Commission's health care antitrust enforcement resources has been directed at assuring that innovative delivery systems have not been unreasonably restricted by the combined efforts of market incumbents.

Where the joint activity of the providers creates market power, the Commission and the courts will weigh all factors in order to assess whether, on balance, consumer welfare is likely to be harmed or enhanced. The larger the degree of market power resulting from the cooperation of the providers, the less likely it will be that the full benefits from the cooperation will be passed along to the consumer. In our experience, most integrated delivery systems heretofore established have not presented a likelihood of significant market power. It is, however, too early to say whether ongoing integration in anticipation of health care reform will also be so characterized.

Of course, when providers join together merely to fix prices or other terms of dealing with payers and in all other respects remain independent, they are limiting consumer choice rather than expanding it. Such price fixing is characterized as "naked" when it is not ancillary to some broader pro-competitive integration

of the providers. Naked price fixing is a per se violation of the antitrust law. Arizona v. Maricopa County Medical Soc., 457 U.S. 332, 349 (1982). By definition, the per se rule against naked price fixing in no way interferes with efficient integration of health care providers.

2) **Would we relax antitrust standards to allow hospitals and group practices to merge to attain efficiencies in order to help the system meet global budgets?**[20]

Answer:

The usual "antitrust standards" already take into careful account the possibility that a merger of hospitals or physician practices would yield cost savings and other benefits that would flow to consumers (and, presumably, would help meet global budgets). Efficiencies are explicitly recognized in the Federal Trade Commission and Antitrust Division Merger Guidelines as an important factor in the antitrust analysis.[21] Section 4 of the Merger Guidelines explains how efficiencies are to be considered. Efficiencies have also been considered in all five of the fully-litigated hospital merger cases to date.[22] One of those decisions (the district court opinion in Carilion) found the hospitals' efficiency arguments persuasive and allowed the merger to proceed; the other four found such arguments to be factually unpersuasive, but indicated that potential efficiencies would be

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[20] This question is set forth as it was modified after consultation with Senator Durenberger's staff.

[21] Merger Guidelines, supra n. 4.

[22] Federal Trade Commission v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991), rev'g 1991-1 Trade Cas. (CCH) ¶¶ 69,400, 69,444 (S.D. Ga.) (preliminary injunction proceeding); United States v. Rockford Memorial Corp., 717 F. Supp. 1251 (N.D. Ill. 1989), aff'd, 898 F.2d 1278 (7th Cir.), cert. denied, 498 U.S. 920 (1990); United States v. Carilion Health System, 707 F. Supp. 840 (W.D. Va.), aff'd mem., 892 F.2d 1042 (4th Cir. 1989); Hospital Corp. of America, 106 F.T.C. 361 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987); American Medical Int'l, 104 F.T.C. 1 (1984). We do not include in this discussion the pending Adventist Health System/West litigation (now in administrative proceedings before the Commission), or the Columbia Hospital litigation (in which administrative proceedings are pending, and the related Federal court proceedings were concluded by a stipulated preliminary injunction not accompanied by a court opinion).

given serious consideration if supported by the evidence.[23] Because the antitrust laws do not stand in the way of hospital and physician practice mergers where the potential benefits to consumers from efficiencies outweigh the danger of potential anticompetitive price increases, I believe no "relaxation" of those laws is needed to help meet global budgets.

3) **What are the antitrust implications of who governs the [health] alliances? For example: a local government, a state government, the federal government, a board of individuals from different interests, or a combination of all or for some of the above? What about whether it is non-profit or for-profit or some other organizational structure?**

Answer:

Until the Administration's health care reform proposal is made public, it is difficult to answer this question fully. For example, the answer will depend in part on the nature and scope of the activities that health alliances are expected to undertake. It is possible that the alliances will not be engaged in any conduct that unreasonably restrains trade, in which case their governance structure and for-profit or non-profit status will have no antitrust implications.

Assuming, however, that a health alliance's actions did restrain trade, its governance structure may have important antitrust implications. If the health alliance is an arm of the federal government, then its actions will not be subject to the federal antitrust laws. If a health alliance is governed by a state or local government, or by private parties, its conduct may be exempt from antitrust scrutiny if the conduct meets the Supreme Court's requirements for finding state action immunity,[24]

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[23] See our response to Senator Hatch's question #7, below, for a discussion of some reasons why hospitals' efficiency arguments may be unpersuasive in some instances.

[24] Courts have stated that the actions of private parties may be insulated from the antitrust laws under the "state action doctrine" if two conditions are met. First, the state must clearly articulate a policy to displace competition with regulation. Second, the state must actively supervise the private parties. Federal Trade Commission v. Ticor Title Ins. Co., ___ U.S. ___, 112 S. Ct. 2169, 119 L. Ed 2d 410, 422 (1992); City of Columbia v. Omni Outdoor Advertising, Inc., ___ U.S. ___, 111 S.Ct. 1344, 1348-1351 (1991); Patrick v. Burget, 486 U.S. 94 (continued...)

or there is an express or implied repeal of the antitrust laws for the conduct under the legislation creating the system.[25]

The status of a health alliance as for-profit or nonprofit would not appear to have direct implications for applicability of the antitrust laws to the alliance's actions; experience has shown that nonprofit entities can and do engage in conduct that hurts competition and consumers, and the Sherman Act does not distinguish between anticompetitive actions by for-profit and nonprofit entities.[26] Likewise, the Clayton Act has been held to

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[24](...continued)
(1988); Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48 (1985); Town of Hallie v. City of Eau Claire, 471 U.S. 34 (1985); Community Communications Co., Inc. v. City of Boulder, 455 U.S. 40 (1982); California Retail Liquor Dealers Ass'n. v. Midcal Aluminum, Inc., 445 U.S. 97 (1980); City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389 (1978); Bates v. Arizona State Bar, 433 U.S. 350 (1977); Cantor v. Detroit Edison Co., 428 U.S. 579 (1976); Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975); Parker v. Brown, 317 U.S. 341 (1943).

[25] For the Supreme Court's views on the limited circumstances justifying a finding of implied antitrust repeal, see National Gerimedical Hospital & Gerontology Center v. Blue Cross of Kansas City, 452 U.S. 378 (1981); Gordon v. New York Stock Exchange, 422 U.S. 659 (1975); United States v. National Ass'n. of Securities Dealers, Inc., 422 U.S. 694 (1975); Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975); Federal Maritime Commission v. Seatrain Lines, Inc., 411 U.S. 726 (1973); Otter Tail Power Co. v. United States, 410 U.S. 366 (1973); United States v. Philadelphia National Bank, 374 U.S. 321 (1963); Silver v. New York Stock Exchange, 373 U.S. 341 (1963); United States v. Borden Co., 308 U.S. 188 (1939).

[26] See, e.g., National Collegiate Athletic Association v. Board of Regents of the University of Oklahoma, 468 U.S. 85 (1984) (holding nonprofit, unincorporated association, whose members were nonprofit colleges and universities, to have violated the Sherman Act by adopting agreement restricting televising of college football games). The Supreme Court stated:

> There is no doubt that the sweeping language of § 1 [of the Sherman Act] applies to nonprofit entities, Goldfarb v. Virginia State Bar, 421 U.S. 773, 786-787 (1975), and in the past we have imposed antitrust liability on nonprofit entities which have engaged in anticompetitive conduct, American Society of Mechanical Engineers, Inc. v. Hydrolevel
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> (continued...)

apply to potentially anticompetitive mergers and acquisitions involving nonprofit hospitals.[27] In some situations, the Federal Trade Commission lacks jurisdiction under the FTC Act over non-profit organizations.[28] However, non-profit entities over which the Commission lacks such jurisdiction may still be liable for violations of the antitrust laws in actions brought by the FTC under the Clayton Act, by the Antitrust Division of the Department of Justice, or by injured private parties.

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[26](...continued)
Corp., 456 U.S. 556, 576 (1982). Moreover, the economic significance of the NCAA's nonprofit character is questionable at best. Since the District Court found that the NCAA and its member institutions are in fact organized to maximize revenues, . . . it is unclear why petitioner is less likely to restrict output in order to raise revenues above those that could be realized in a competitive market than would be a for-profit entity.

(Id. at 100 n.22)

[27] See, e.g., Federal Trade Commission v. University Health, Inc., 938 F. 2d 1206 (11th Cir. 1991); United States v. Rockford Memorial Corporation, 898 F. 2d 1278 (7th Cir. 1990), cert. denied, 498 U.S. 920 (1990) (dictum). See also Federal Trade Commission v. Columbia Hospital Corporation, Civil Action No. 93-30-CIV-FTM-23D (M.D. Fla. May 21, 1993) (Stipulated Preliminary Injunction and Final Order); Hospital Corporation of America v. FTC, 807 F. 2d 1381, 1390-1391 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987).

[28] See Community Blood Bank v. Federal Trade Commission, 405 F.2d 1011, 1015-20 (8th Cir. 1969). The Federal Trade Commission has been held to have jurisdiction over non-profit organizations that have members, and are organized to carry on business for the profit of those members. American Medical Ass'n, 94 F.T.C. 701, 993-96 (1979), enforced as modified, 638 F.2d 443 (2d Cir. 1980), aff'd per curiam by an equally divided court, 455 U.S. 676 (1982).

III. Questions from Senator Hatch

1) Many health care providers are asking for greater certainty and clarity of antitrust rules governing collaborative arrangements. Is there any way to make an exhaustive list of approved or disapproved activities or arrangements? Could you suggest some market power or other forms of safe harbors below which joint activity would not likely pose threats to competition? Perhaps you could respond to this question by explaining what types or magnitudes of efficiencies and the respective weight given them when you analyze mergers or collaborations.

Answer:

First, let me note that antitrust enforcement is probably more well defined as it is applied to healthcare than any other single industry. My response to question 5 from Senator Rockefeller provides some detail on this point. Indeed, the American Hospital Association has acknowledged that "[t]he general analytical framework for analyzing the antitrust ramifications of hospital mergers is well established."[39] It has also characterized the Commission's advisory opinion procedure as "a relatively clear signal as to whether the Commission would challenge...[a merger] if the parties moved forward."[40]

While it is not possible "to make an exhaustive list of approved or disapproved activities or arrangements...," the analytical processes are well known. In the case of mergers, the Commission and the Department of Justice have jointly issued a detailed set of enforcement guidelines.[41] In the case of other horizontal arrangements, the doctrine of ancillary restraints provides a clear analytical framework and in a broad sense provides a safe harbor for efficiency-enhancing joint activity. That doctrine holds that an otherwise illegal horizontal cooperation may be permitted when the parties are also

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[39] American Hospital Association, Hospital Mergers: An Executive's Guide through the Antitrust Thicket, at 20 (September 1989).

[40] Id. at 9-10.

[41] Merger Guidelines, supra n. 4. See also letter dated June 8, 1993, from Chairman Steiger to Senator Hatch.

cooperating in a broader venture which enhances rather than limits consumer choice. In order for the doctrine to apply, the restraint must be necessary to make the broader venture work.

Assume, for example, that there is a community with 100 physicians. If, say, five of those physicians agree to fix prices, and nothing more, that would be a per se violation of the Sherman Act. The law assumes there are no benefits to society from naked restrictions on price. It does not matter under the law whether the price fixing is effective -- since there are no offsetting benefits there is no reason to allow any tampering with price at all. But assume instead the same five physicians join together in partnership and as part of the partnership agreement they fix the prices they will charge. It seems clear that the price fixing is ancillary to the partnership and that the partnership is likely to enhance consumer choice; for example the partnership may allow each physician to specialize in a certain area of practice.

The fact that a restraint is ancillary to a larger pro-competitive venture does not necessarily end the inquiry -- if the market power created by the venture is significant it may, on balance, result in a lessening of consumer choice. In many instances, however, the collaborative arrangements we see in the healthcare industry do not present a likelihood of market power. Therefore, a showing that a restraint is ancillary to a broader procompetitive venture is often an effective safe harbor; at the very least it is a clear and easy-to-apply analytical model.

The Commission does examine efficiencies and weigh them in a rule of reason analysis. As a general proposition, the more significant the competitive injury posed by a merger or other collaboration, the greater assurance the Commission requires that efficiencies will offset that anticompetitive potential. The types and scope of efficiencies that the Commission considers in mergers, which are also applicable to other collaborations, are discussed in the Department of Justice and Federal Trade Commission Horizontal Merger Guidelines § 4, which state in part:

> Cognizable efficiencies include, but are not limited to, achieving economies of scale, better integration of production facilities, plant specialization, lower transportation costs, and similar efficiencies relating to specific manufacturing, servicing, or distribution operations of the merging firms. The Agency may also consider claimed efficiencies resulting from reductions in general selling, administrative, and overhead expenses, or that otherwise do not relate to specific manufacturing, servicing, or distribution operations of the merging firms, although as a practical matter, these types of efficiencies may be difficult to

> demonstrate. In addition, the Agency will reject claims of efficiencies if equivalent or comparable savings can reasonably be achieved by the parties through other means. The expected net efficiencies must be greater the more significant are the competitive risks identified . . . .

Merger Guidelines § 4.

In addition, the Commission examines the likelihood that claimed efficiencies will be realized, that the efficiencies will be passed on to consumers as lower prices, and that the efficiencies can be achieved by means other than the proposed merger. Unsubstantiated claims of efficiencies, or claims of efficiencies that will not directly benefit consumers, are given less weight than well documented claims of efficiencies that will likely lead to lower prices or a higher quality of care.[32] Because information relating to efficiencies is often under the control of the parties to the merger, the Commission has required proponents of a merger to present evidence demonstrating any efficiencies claimed.[33]

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[32] We note that in two of the three cases where efficiencies were addressed by the federal courts, courts have held that the defendants in hospital merger cases have failed to prove their claims of substantial efficiencies. See United States v. Rockford Memorial Corp., 717 F. Supp. 1251, 1291 (N.D. Ill. 1990), aff'd, 898 F.2d 1278 (7th Cir.), cert. denied, 498 U.S. 920 (1990) ("the defendants have failed to clearly and convincingly demonstrate that the merger will, in fact, create a net economic benefit for the health care consumer"); Federal Trade Commission v. University Health, Inc., 938 F.2d 1206, 1233 (11th Cir. 1991) ("appellees here have not presented sufficient evidence to support their claim that the intended acquisition would generate efficiencies benefiting consumers").

[33] Under the 1968 Department of Justice Merger Guidelines, efficiencies were not considered in assessing the likely anticompetitive effects of a merger. In 1982, the Department of Justice revised its Guidelines to recognize that an evaluation of efficiencies might be undertaken in merger analysis in certain circumstances. In 1984, the Department of Justice revised and reissued its Merger Guidelines, to state that if a party to an otherwise anticompetitive merger could demonstrate by "clear and convincing evidence" that efficiencies would outweigh the likely anticompetitive effects, the Department might not bring an enforcement action. The Merger Guidelines issued by the FTC and the Department of Justice in 1992 continue to recognize that the agencies may forgo an enforcement action, if parties can

(continued...)

2) I suggested to Chairman Steiger of the FTC at another hearing on this subject that most hospital mergers occur in markets which are already quite concentrated according to traditional merger guidelines assumptions -- indeed any market which has fewer than six hospitals will have an HHI over 1800, meaning that the market is "highly concentrated" and therefore would receive serious antitrust scrutiny. A market with fewer than six hospitals is likely the rule, not the exception. Doesn't this suggest that there might need to be different standards for health care or at least hospital antitrust analysis?

Answer:

The primary statute relied upon by the Commission in achieving the goal of its merger enforcement program is Section 7 of the Clayton Act, 15 U.S.C. § 18.[4] It prohibits mergers where, "the effect of such acquisition may be substantially to lessen competition, or tend to create a monopoly." This statute focuses on the future effects of a transaction. Thus, to determine whether a proposed merger would violate Section 7, and injure consumers, the Commission must determine the likely effect of the merger on competition and consumers in the post-merger market. Consumers are injured when they are required to pay higher prices for products than they would pay without the merger.[5] A merger can lead to higher prices if the merger creates or enhances market power -- the ability of a single firm, or group of firms, profitably to charge prices above a competitive price level.

It is not possible simply by observing the prices and quantities of services and the number of firms operating in an area to determine whether competition would be substantially lessened as a result of a merger. Therefore, in making a determination that competition is likely to be substantially

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[3](...continued)
demonstrate that efficiencies from an otherwise anticompetitive transaction outweigh the likely adverse effects.

[4] The Commission has also challenged mergers under Section 5 of the Federal Trade Commission Act, as unfair methods of competition.

[5] Lowering the quality of goods while holding price constant has the same detrimental effect on consumers as increasing prices. As it is used here, the term "price increase" includes any increase in price after adjusting for any change in quality.

lessened by the acquisition, the Commission must consider many factors relevant to the operation of a competitive market. The market concentration, which reflects the number of firms operating in a market, is one such factor.

Under the Merger Guidelines, concentration is measured by the Herfindahl-Hirschman Index ("HHI"). The HHI is calculated by summing the squares of the individual market shares of all the firms participating in the market.[36] The HHI reflects the distribution of market shares among the firms in the market. Under the Merger Guidelines, markets with a post-merger HHI exceeding 1800 are designated highly concentrated.[37] In deciding whether to challenge mergers in such highly concentrated markets, the starting point is the increase in the HHI caused by the merger. Mergers that produce an increase in the HHI of less than 50 "are unlikely to have adverse competitive consequences." Merger Guidelines § 1.51(c). Mergers that produce an increase in the HHI of more than 50 points in highly concentrated markets "potentially raise significant competitive concerns," Merger Guidelines § 1.51(c), and mergers that produce an increase in the HHI of over 100 points are presumed "likely to create or enhance market power or facilitate its exercise," Merger Guidelines § 1.51(c). In the latter two cases, mergers in highly concentrated markets that produce an increase in the HHI of over 50 points or over 100 points, the Commission considers the qualitative factors listed in Sections 2-5 of the Merger Guidelines in determining whether to challenge a transaction. These include the potential adverse competitive effects of mergers (Merger Guidelines § 2), entry analysis (Merger Guidelines § 3), efficiencies (Merger Guidelines § 4), and failure and exiting assets (Merger Guidelines § 5).

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[36] For example, a market consisting of five firms with market shares of 30 percent, 25 percent, 15 percent, 15 percent and 15 percent has an HHI of 2200 ($30^2 + 25^2 + 15^2 + 15^2 + 15^2 = 2200$). The HHI ranges from 10,000 (in the case of a pure monopoly) to a number approaching zero (in the case of an atomistic market). Merger Guidelines § 1.5 n. 17.

[37] Because your question specifically asks about highly concentrated markets, we focus our response on such markets. The Merger Guidelines note that in moderately concentrated markets, markets in which the HHI is between 1000 and 1800, "[m]ergers producing an increase in the HHI of more than 100 points . . . potentially raise significant competitive concerns depending on the factors set forth in Sections 2-5 of the [Merger] Guidelines." Merger Guidelines § 1.51(b). The Commission has not challenged a hospital merger in a market that had a post-merger HHI below 1800.

Market shares and concentration measured by the HHI constitute relevant information in analyzing the likely competitive effects resulting from a merger, because the smaller the number of market participants and the higher the market concentration, the more likely that the acquisition will lead to a substantial lessening of competition, all other factors being equal. If there are many hospitals in a relevant market, so that each has a small share and the market is unconcentrated, it is unlikely that the merged hospital could raise prices or decrease service or quality unilaterally because patients could turn to other hospitals. The larger the number of firms remaining in a market, the less likely that the acquisition will facilitate collusion. In unconcentrated markets, the likelihood of collusion is considered remote, and enforcement actions are not taken. As the number of independent hospitals in a relevant market decreases, and the market shares and HHI figures increase, it becomes more likely that competition will be substantially lessened by the transaction. As the market becomes more concentrated, the Commission scrutinizes the proposed merger more thoroughly.

If concentration numbers in the relevant market lead to an inference that the acquisition could lead potentially to significant competitive problems, the Commission proceeds to analyze other factors relevant to the operation of the market. The analysis seeks to determine whether the acquisition will facilitate collusive activity among the remaining hospitals in a market or allow for unilateral price increases.

A review of past Commission investigations of hospital mergers does not suggest a need for concentration standards different than those discussed above to analyze hospital mergers and acquisitions. It should be noted that the data indicates that most hospital mergers and acquisitions did not involve hospitals that competed in markets that are highly concentrated. From fiscal year 1981, through fiscal year 1992, the Commission staff reviewed over 300 Hart-Scott-Rodino filings that related to mergers and acquisitions of hospitals.[38] After examining those

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[38] While both the Department of Justice and the Federal Trade Commission generally have jurisdiction over mergers, the two agencies have established a liaison arrangement. Pursuant to that arrangement, neither agency will undertake an antitrust investigation until it requests and is granted "clearance" from the other agency. At the time of such a clearance request the agencies decide among themselves which one will investigate the matter. Through this process, only one federal antitrust agency investigates any particular transaction. The number of filings in the text includes only those filings where the Department of Justice did not request clearance.

premerger filings, the staff only sought to open investigations in 25 instances.[39] In 14 of these 25 instances, the staff was able to resolve the matter after opening an investigation, but before issuing Hart-Scott-Rodino requests for additional information to the parties to the merger or acquisition. In only 11 instances did the staff find it necessary to issue Hart-Scott-Rodino requests for additional information.

In those cases where the staff were able to identify a plausible, highly concentrated market in which the hospitals competed, the Commission only challenged a handful of acquisitions. Including all hospital mergers and acquisitions reviewed by the Commission,[40] both those for which a Hart-Scott-Rodino filing was required, and those for which no filing was made, from fiscal year 1981 through fiscal year 1992, only 26 hospital mergers were identified where there was sufficient concern to warrant substantial investigation. In most of these cases there was a plausible market in which the two parties competed and which was highly concentrated. Upon the completion of the investigations, the Commission challenged only 5 of those 26 mergers.

-- Don't any actors face heightened antitrust risks in such small markets?

Not necessarily. As the number of independent firms in a relevant market decreases, and the market shares and concentration levels increase, it becomes more likely that competition will be substantially lessened by the transaction. As the market becomes more concentrated, the Commission scrutinizes the proposed merger more thoroughly. But, as indicated in the foregoing response, most hospital mergers have withstood antitrust scrutiny, including many in highly concentrated markets.

-- Could any safe harbor rules work in such small markets?

Answer:

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[39] In these 25 instances the Federal Trade Commission staff sought clearance from the Department of Justice to conduct an investigation.

[40] This number excludes those mergers and acquisitions for which the Department of Justice sought clearance.

The Merger Guidelines already define concentration levels that "are unlikely to have adverse competitive consequences and ordinarily require no further analysis." I understand this question to ask whether, in the case of hospitals, such concentration levels could or should be defined to include at least some markets with fewer than six hospitals. Our enforcement experience has shown that mergers in markets with less than six hospitals may be likely, in light of the variety of factors already discussed, to lessen competition and harm consumers.[41] Based on this experience I do not believe that a safe harbor rule could be devised to include markets with "fewer than six hospitals."

-- Should there be different antitrust rules for small or rural areas, which are often underserved -- perhaps partly because they have higher antitrust risks and lower, not higher, provider profits to encourage market entrants.

Answer:

I know of no evidence suggesting that actual or perceived antitrust risks have adversely affected the level of hospital services available in small or rural areas. Nor do I know of any basis for applying different antitrust rules for small or rural areas. To the extent that market conditions in rural or small markets affect the likelihood that a merger would have anticompetitive affects, the Commission would consider those market conditions in deciding whether to bring an enforcement action against the merger.

3) Market definition is perhaps the most difficult issue in antitrust analysis. Is there any way to provide greater clarity about market boundaries for health care markets which would take into account such distinctions as the difference between the markets for general and tertiary care, the various medical specialties, and other such different markets?

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[41] See FTC v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991).

Answer:

Defining a relevant market for antitrust purposes (essentially, identifying the competitors, if any, in a position to significantly restrain non-trivial price increases or quality decreases for a service affected by the business activity under consideration) requires consideration of many factors specific to the service and the local area in question -- including some relevant factors identified in your question. The best generalization I can offer, discussed in more detail below in my response to the third part of this question #3, is that health care providers seem to be well acquainted with the markets relevant to their business decisions which take fully into account their local circumstances.

"Rules of thumb" for market definition tend to be unreliable because of the wide range of factors potentially affecting market definition, which vary among different areas of the country and different mergers or other activities. These factors include, but are not limited to, topography (e.g., mountain ranges or bodies of water which separate hospitals in different communities, and may isolate merging hospitals from each other or from other hospitals); road and weather conditions (which may facilitate or hinder travel to obtain health care); the average age of the population (which may affect the ability to obtain health care outside the community); population density and distribution (e.g., do the areas between communities contain substantial populations for which hospitals in more than one community can effectively compete?); and commuting and trade patterns (do people in a community regularly work and shop, and perhaps could readily also choose to obtain their health care, in other communities?). The wide variations in local circumstances between different regions, or even within a region, preclude us from reliably defining markets without considering those local circumstances.

I agree with your suggestion that the specific health service(s) affected by the activity in question can be another variable relevant to the definition of hospital and other health service markets. For example, a health plan's subscribers may be generally unwilling to travel outside their communities for primary, "bread-and-butter" hospital services, but might not object to having to occasionally travel longer distances for uncommon and unusually expensive procedures (such as organ transplants). In general, the less common and more sophisticated the service, the broader will be the area in which providers of that service can effectively compete with each other. Moreover, differences in the services offered by community hospitals offering only primary- or secondary-level services, and teaching

hospitals focusing on the more sophisticated tertiary services, may significantly affect competition among hospitals in a particular area and therefore the antitrust analysis. Such differences may, for example, diminish the competitive "overlap" between a teaching hospital proposing to acquire a small community hospital providing basic services which the teaching hospital does not focus on. Conversely, those differences may heighten the antitrust concerns raised by a merger of two large tertiary hospitals (whose significant competitors, if any, may include only other such hospitals in their own or adjacent metropolitan areas, rather than smaller hospitals in their own community). Similar considerations would influence how markets are defined for non-hospital services (for example, physician specialties).

-- **How could such market definitions take into account the relative price-insensitivity of consumers, i.e., traditional antitrust analysis applied a 5% price increase rule to find where substitutes might come from if a monopolist set supra-competitive prices, what would be the correct number, 5%, 10%, 15%, etc.?**

Answer:

Health care "consumers" (broadly defined) who would be affected by price increases are sufficiently sensitive to health care prices to make the "5% price increase rule" for antitrust market definition[42] sensible in health care markets. Many privately-insured patients are sensitive to price differences among health care providers, because they have to pay part of those differences through 10% or 20% "co-payments". More importantly, their health plans (particularly "managed care" plans such as HMOs and PPOs) often are sensitive to "small but significant" price differences or increases, and are quick to take business away from overpriced providers if they have competitive alternatives to which they can turn to serve their beneficiaries. The enforcement agencies generally consult with such health plans (where such plans are prevalent) when trying to determine whether a price increase in a given area would be profitable or counterproductive for the hospitals in the area.

Moreover, even to the extent that individual consumers are insensitive to price increases (or that price is influenced by government regulation, as is generally the case with conventional Medicare reimbursement for inpatient hospital care), consumers and their physicians are nonetheless normally sensitive to

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[42] Merger Guidelines § 1.11.

hospital quality decreases. When defining markets, the Commission considers how consumers and doctors would respond to attempts not only to make patients pay more for hospital care, but also to provide fewer or lower-quality services for their (or their health plans') money. It is normally possible to make at least a rough determination of how consumers and their doctors would respond to "small but significant" hospital quality changes, notwithstanding the difficulty of defining what exactly is a 5% reduction in hospital quality.

-- **How is an average health care provider supposed to apply such standards as the "small but significant and nontransitory" price increase in evaluating its business decisions?**

Answer:

I believe health care providers commonly do apply such a standard (albeit not in the same words) in making their business decisions.[43] Indeed, in defining relevant markets the enforcement agencies place considerable weight on how hospitals and other providers define their own markets in internal planning documents, and in the context of specific business decisions.

Hospital executives and other health care providers typically determine who their institutions compete with and who would be in a position to defeat significant price increases as part of their ongoing management planning. Those executives know where the patients in their areas go (or could readily go) for hospital care, and which hospitals local physicians use (or could readily use) to treat their patients. They regularly ask and answer these and other questions similar to the questions that antitrust agencies (and courts, as reflected in their hospital merger case decisions) ask when defining hospital markets. These questions include:

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[43] The "small but significant and nontransitory" standard, I believe, accords with how most business executives view their markets, to identify the competitors that are in a position to threaten or limit their companies' business success. The "small but significant and nontransitory" standard recognizes, as executives generally do, that it is imprudent to focus narrowly on the competitors to whom consumers would turn in response to merely trivial price increases; that would not identify all the competitors who could readily capture a company's customers. On the other hand, it is normally not productive for a company to pay much attention to "competitors" who could acquire the company's customers only if there were a disastrous decline in the company's cost and quality performance.

— Can, or do, health plans readily serve subscribers in our local community using hospitals located elsewhere? Do health plans threaten to send their patients to hospitals in other communities if our prices are unsatisfactory to them? If they do, are those threats empty, or do we believe that the plans will follow through on them if we don't offer the prices they want?

— Which other hospitals' competitive moves do we need to watch, and consider responding to (or simply must respond to)? Which hospitals have demonstrated the ability to gain substantial market share in the communities we serve, or to increase their share by cutting prices or improving service quality? Which hospitals are too far away to have the realistic potential to affect our patient base?

— What other hospitals have benefitted from any problems we have had with service quality or excessive prices?

— In which other communities do we consider it worthwhile to market our services? From which communities could we get substantially more patients if we reduced prices or improved services?

Practical business decisions of this kind help hospital executives define their markets. In documents prepared for internal business purposes, they generally reach conclusions on what their markets are, and on who are and are not significant competitors. We typically find these business conclusions to be reasonable, consistent with the conclusions we draw from other information, and valuable evidence in the cases we bring to court.

4) **You have mentioned that the FTC and DOJ have investigated or challenged only a small percentage of hospital mergers or collaborations, but the costs of such an investigation or challenge to a small hospital in a small city or town can be devastating. Is there any way of reduoing the risk of antitrust**

costs associated with investigations or other enforcement activities which would allow for checks on anticompetitive activity without devastating the providers?

Answer:

The Commission never seeks to impose costs on the parties to a merger that are not necessary to the Commission's investigation. Moreover, the Commission itself faces resource constraints and seeks to resolve investigations in the most efficient, timely manner. However, merger investigations must necessarily cover an extensive range of issues, and the Commission cannot fulfill its obligations to enforce the Clayton Act and the Federal Trade Commission Act without imposing some costs on the parties under investigation.

The Commission does structure its investigations in an effort to minimize the costs for parties whose merger comes under investigation. The Commission does so by identifying key facts to be examined first. As soon as the Commission can determine that the merger will not substantially lessen competition, the investigation is closed. In many instances, this has been done even before a Hart-Scott-Rodino second request is issued. From 1981 through 1992, of 25 Hart-Scott-Rodino hospital mergers for which the Commission sought clearance from the DOJ and began an investigation, 14 investigations were closed before Hart-Scott-Rodino second requests were issued.

The parties can cooperate with the Commission to minimize the costs of achieving an early resolution of investigations. Often parties will communicate with staff before or shortly after a Hart-Scott-Rodino filing, and assist in identifying for the staff the key issues whose resolution favorable to the parties will allow the investigation to be closed. The parties can cooperate further by providing information and data to the Commission before the issuance of a Hart-Scott-Rodino second request, or by providing the critical information responsive to a second request without waiting for the compilation of all the required information. In fact, all of these approaches have been successfully pursued by hospitals contemplating a merger.

The Commission has developed a "quick look" procedure for investigations in which the Commission issues a Hart-Scott-Rodino second request, but can identify critical information that it believes may resolve an investigation. It will identify that information to the parties when the Hart-Scott-Rodino second request is made, and agree to examine the parties' response and determine whether it resolves the issues of the case, even before the parties have fully complied with the second request. If the response does resolve the issues of the investigation, the

investigation is closed even though the parties have not fully responded to the second request.

Finally, parties who intend to merge can use the Department of Justice and Federal Trade Commission Merger Guidelines to make a realistic assessment of the likelihood of an antitrust challenge to the merger before pursuing it. At the beginning of an investigation, the parties typically have a sound grasp of the relevant facts, and working with their antitrust counsel, can apply the Merger Guidelines to the facts of their transaction. The parties can then assess the likelihood of an antitrust challenge, and determine if they wish to pursue the transaction.

5) **You have suggested that antitrust law and competition have a role to play in the health care market. But there are reasons to believe that for many reasons health care is not wholly like most other markets. For example, health care consumers may often need to make urgent decisions about a course of medical care without the benefit of a good deal of information (e.g. emergency room services). Can you point to other markets in which the consumers do not directly pay for what they buy, or in which the costs of information are so high to consumers that they must rely on information other than economics to make decisions, etc?**

If there are any, what are the lessons for health care?

Answer:

Certainly, many professional service markets do not fit the economic model of perfect competition. As is common in such markets, health care consumers often lack good information about price and quality of services. Furthermore, the historic prevalence of traditional indemnity insurance has had a major impact on consumer behavior in certain professional service markets. While such insurance has not been restricted to health care, it probably has been more pervasive factor in health care markets than in most non-health care markets.

The market, however, is rapidly developing ways of dealing with the imperfections noted in your question. Managed care arrangements shift the focus of competition from the consumer's purchase of medical care to the purchase of insurance, where the price and quality differences among plans are visible to the consumer. They ameliorate the individual consumer's information disadvantage by permitting large buyers with much greater access to information to contract with providers. These contracts permit issues such as price, qualifications of providers, and standards for utilization of services to be determined in advance of the individual consumer's need for medical care. Managed care

organizations can negotiate favorable terms only where there is competition among provider groups, and active antitrust enforcement serves to ensure that markets remain open for such competition to flourish.

6) **There are studies by the GAO that suggest that health care costs are lower and quality and satisfaction is higher in areas like Rochester, NY, where all the actors sit down together and cooperate, rather than compete, to make community health care decisions. There are other Inspector General of HHS, CBO, and other reports that suggest that, contrary to traditional antitrust assumptions, hospital costs and prices are higher where there is competition than where there is cooperation or mergers. What implications do these studies have regarding antitrust policy?**

-- Could we not fashion some clear guidance or safe harbors or could not community-involvement or buyer approval be used as a bright line tests for provider collaboration arrangements?

Answer:

Neither the GAO's study of health care in Rochester[44], nor other recent reports on health care in Rochester[45] identified any single characteristic as being responsible for Rochester's lower health care costs. For example, the GAO's study identified regional health facility planning and community rating as merely two of several factors contributing to lower costs and better access to health care in Rochester. The study also identified such factors as the existence of a single, dominant insurer (Blue Cross/Blue Shield covers more than 70 percent of the population), the large amount of managed care (55 percent of population enrolled in HMOs), and the active involvement in health care issues by large area employers.

In addition, the GAO study noted that the use of global budgets under which Rochester hospitals operated from 1980-1987

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[44] United States General Accounting Office, Health Care: Rochester's Community Approach Yields Better Access, Lower Costs, (GAO/HRD-93-44) (January 1993).

[45] See, e.g., W. J. Hall and P. F. Griner, "Cost-Effective Health Care: The Rochester Experience," 12 Health Affairs 58 (Spring 1993); C. Stevens, "Are Clouds Closing In On The Rochester Miracle?" 70 Medical Economics 106 (April 26, 1993).

appears to have contributed substantially to controlling costs. The GAO study reported that when global budgets were in place, per capita hospital costs in Rochester grew at a slower rate than costs for other hospitals in New York State or nationally. However, in the first three years after global budgets for hospitals were eliminated (1987-1990), average annual per capita hospital cost increases in Rochester were almost 20% greater than for the rest of New York State (7.3% versus 6.1%), and were almost 50% greater than such increases nationwide (7.3% versus 4.9%).

Much of the "cooperation" in Rochester appears to have been between business leaders in the community, health care providers, insurers, and the government. This cooperation more closely resembled vertical integration than cooperation (or collusion) between competitors that can injure consumers that the antitrust laws are concerned with. Consequently, I do not believe that the Rochester experience provides a basis for concluding that cooperation is preferable to competition in controlling health care costs or improving access to care.[46] Moreover, even if cooperation were a key to Rochester's success, it does not follow, as the GAO study cautions, that such success could be replicated in other markets whose health care systems developed and function differently from the rather atypical situation in Rochester.

As to studies purportedly demonstrating that hospital costs and prices are higher where there is competition than where there is cooperation or mergers, it is difficult to respond in detail absent specific identification of the studies. However, I understand that several studies purporting to reach such counter-intuitive conclusions are subject to serious methodological

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[46] The Federal Trade Commission has intervened to stop one instance of "cooperation" by health care providers in Rochester that was alleged to have caused consumer harm. In 1985, the Commission issued a complaint against 35 anesthesiologists in Rochester (all the anesthesiologists practicing at Rochester's three largest hospitals), alleging that they had conspired to increase their fees by collectively negotiating with third-party payors over reimbursement terms, and by threatening not to participate in certain plans (including Blue Shield and one HMO) if their demands were not met. It was further alleged that the anesthesiologists in fact had jointly departicipated from Blue Shield when their demands were not met. The matter was settled in 1988 when the anesthesiologists entered into a consent order whereby they agreed not to conspire to deal with third-party payors on collectively determined terms or to coerce such payors. Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order).

criticisms, or do not really address the issue that you have posed. Moreover, I also am aware of other studies, whose methodological soundness has been scrutinized and confirmed, which demonstrate that hospital prices in fact are lower in markets where there is competition than in ones where such competition is absent.[47] I therefore do not believe that there is serious analytical or empirical support for concluding that health care competition leads to higher prices, or that cooperation and mergers leads to lower prices for consumers.

I believe it is possible to provide "clear guidance" for collaborative arrangements among health care providers. As I noted in my response to your first question, a showing that a restraint is ancillary to a broader procompetitive venture is often an effective safe harbor; at the very least is a clear and easy to apply analytical model. As to your inquiry concerning the use of community involvement or buyer approval as a bright-line test, in making assessments about competitive effects, antitrust law enforcers routinely seek out, consider, and give great weight to the opinions of representatives of the community and buyers who are more familiar with a particular local market than we are. Thus, such views are extremely important in reaching determinations about collaborative arrangements that are not per se illegal. There are many reasons why such opinions may not be dispositive, however. For example, in a recent case some buyers favored a proposed merger because they believed that the merger was necessary to establish a second obstetrics program in the community. The views of those buyers were appropriately discounted when the parties to the proposed merger admitted that a second obstetrics program would be added regardless of whether the merger took place. Because there may be many circumstances where, when all the facts are known, the opinions of buyers or community representatives may not be dispositive, I do not believe it is possible to fashion a bright-line rule tied to such opinions.

Finally, as you are aware, the Federal Trade Commission has in place procedures whereby providers can seek and obtain formal opinions or less formal guidance as to whether proposed collaborative arrangements are likely to raise antitrust concerns. Frequently, it takes nothing more than a brief telephone conversation with Commission staff to learn that a

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[47] See, e.g., Melnick, Zwanziger, Bamezai, and Pattison, "The Effects of Market Structure and Bargaining Position on Hospital Prices," 11 Journal of Health Economics 217-233 (October 1992); D. Dranove, S. Shanley, and W. White, "Price and Concentration in Hospital Markets: The Switch from Patient-driven to Payor-driven Competition," ___ Journal of Law and Economics ___ (1993) (forthcoming).

course of conduct raises no substantial antitrust issues. Many health care providers and counsel have used, and continue to use, these procedures to allay their concerns about antitrust exposure arising from activities that they are considering undertaking, and we encourage others to do so.

7) **There are studies which suggest that quality as measured by survival and success rates, and efficiencies of cost and speed can be achieved by economies of scale (and scope) -- some of the literature suggests that hospitals smaller than 200 beds or patients can not function efficiently. Yet the FTC has challenged the merger of two hospitals which had 43 and 51 beds for a total post merger size of 94 beds. While I know you can not comment on particular cases, does this not add to a perception problem or lead to uncertainty for providers who think they are making cost-saving, efficiency-driven decisions?**

Can we not provide clearer guidance?

The FTC, in deciding whether or not to investigate or challenge a hospital merger, gives very careful consideration to possible efficiencies from the merger, including but not limited to scale economies. However, whether a particular merger might benefit consumers because of scale economies or other efficiencies depends not only on the size of the merging hospitals, but also on other factors affecting whether those economies will be in fact achieved and will be passed on to consumers (rather than, for example, stockholders of the merged hospital's corporate parent). In short, merging two small hospitals does not necessarily yield a lower-priced large hospital.

The fact-specific character of these issues is reflected in the four hospital merger case decisions which have addressed them.[48] All four decisions considered the hospitals' arguments justifying their mergers (or proposed mergers) on the basis of scale economies or other efficiencies. Three of those decisions found those arguments factually unpersuasive.

The health economics literature suggests that, up to a point, large hospitals can operate more efficiently or provide

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[48] Federal Trade Commission v. University Health, Inc., 938 F. 2d 1206 (11th Cir. 1991); United States v. Rockford Memorial Corporation, 717 F. Supp. 1251 (N.D. Ill. 1989), aff'd, 898 F. 2d 1278 (7th Cir. 1990), cert. denied, 498 U.S. 920 (1990); United States v. Carillon Health System, 707 F. Supp. 840 (W.D. Va.), aff'd mem., 892 F.2d 1042 (4th Cir. 1989); American Medical International, 104 F.T.C. 1 (1984).

higher-quality services than small hospitals. However, there is little consensus in that literature on where to draw the dividing line between "large" and "small," or how substantial the benefits of increased scale really are. I offer the following broad generalizations about hospital scale economies without attempting to draw bright lines or definitive conclusions where none are possible:

— Most hospital scale economies are exhausted at 100 beds.[49]

— Above 100 beds, up to somewhere over 200 beds, increases in hospital size and volume may be associated with some scale economies, but those economies are usually not substantial.[50]

— The foregoing conclusions apply only to hospitals whose inpatient facilities are located at a single site. I am not aware of any studies specifically addressing whether hospitals whose beds are divided between two campuses (such as those resulting from hospital mergers where neither of the merged facilities is closed) achieve the scale economies that the economic literature suggests can be attained by single-campus hospitals of similar size.

I emphasize that these are general observations. If a hospital is, for example, operating profitably over time in a competitive market with less than 100 beds, it must be assumed to be at an efficient scale for its particular market.[51] Real world experience should always trump theoretical generalizations. Moreover, there are at least the following significant exceptions to these generalizations. First, hospitals specializing in only one or a few service lines (e.g., children's hospitals, or rehabilitation hospitals) may be able to operate at maximum efficiency with a smaller bed capacity than general hospitals offering a broader range of services. Second, it may be possible for relatively small hospitals to operate at peak efficiency if they can share services or support functions with other institutions (e.g., hospitals in other markets belonging to the

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[49] See trial testimony of Dr. Monica Noether in the 1991 University Health and 1993 Columbia Hospital merger cases.

[50] Id.; M. Vita, J. Langenfeld, P. Pautler and L. Miller, "Economic Analysis in Health Care Antitrust," 7 Journal of Contemporary Law & Policy 73 (1991).

[51] Stigler, "The Economics of Scale", 1 Journal of Law & Economics 54-71 (October 1958).

same multihospital system, or long-term care facilities operated by the hospital), thereby spreading the small hospital's fixed costs over a larger patient base.[52] Third, at some point (not clearly defined by the health economics literature), hospitals may incur diseconomies of scale from being too large to manage effectively.

Even if one or both of the hospitals involved in a merger are below minimum efficient or optimum scale, it is necessary to examine whether the merger will in fact yield scale economies or other benefits. There are a number of reasons why that might not occur in a particular situation, including but not limited to the following:

— The merging hospitals are too far apart to consolidate clinical departments or services without causing substantial inconveniences to at least some of the patients and physicians who now use whichever hospital would lose the departments or services in question. In that case, the inconvenience costs to patients and physicians may outweigh the cost savings of consolidation.[53]

— The one-time capital costs of consolidating two hospitals (or parts thereof) into one may outweigh the present discounted value of future operating cost savings from the increased scale of the remaining facility. For example, the scale economies from operating one 100-bed hospital facility rather than two facilities with 50-beds may not justify the multi-million dollar capital costs of expanding one of the hospitals to make room for the other's patients.[54]

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[52] The same may be true for hospitals that provide unusually high volumes of outpatient care; at such hospitals, outpatients help cover fixed costs that the hospitals would otherwise have to try to recover from inpatients.

[53] These costs may include not only increased travel time and expense for patients, but also costs for physicians from having to either relocate their offices or spend more of their (expensive) time travelling to and from the hospital instead of seeing patients.

[54] Efficiencies are more likely where consolidation can be achieved at minimal expense, e.g., where one hospital already has enough excess capacity (including not only beds, but also related facilities such as operating rooms) to accommodate comfortably the other's patients without new construction. A hospital

(continued...)

— Even if the merging hospitals reasonably anticipated that the costs of merging were outweighed by the resulting efficiencies, unanticipated problems may prevent the hospitals from fully implementing their plans, or eliminate or outweigh the promised benefits.[55] For a wide variety of reasons, hospital mergers do not always work out as well as planned, or are not carried out as smoothly as the merging hospitals had envisioned.[56]

Finally, even if a merger would likely yield scale economies (allowing for the various anticipated costs of consolidation, Murphy's Law, and other obstacles), that does not necessarily benefit consumers. Unless competitive market forces pressure the merged hospitals to pass along cost savings to consumers,[57] those savings may flow instead into the pockets of the hospital's shareholders or into its cash reserves, or may be frittered away if lessened competition dulls the hospital's incentives to take the sometimes painful steps required for stringent control of costs.

Sincerely,

James C. Egan, Jr.
Director of Litigation

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[54](...continued)
consolidation is also more likely to be efficient if there are substantial capital costs to not consolidating — for example, if one of the merging hospitals has excess capacity and the other has physical plant deficiencies so serious that the only realistic alternatives to combining its operations with another hospital's are building an expensive new replacement facility or going out of business.

[55] This is usually less of a concern with joint ventures limited to specific services, such as sharing of magnetic resonance imagers. Those ventures are less complex than mergers of entire institutions, lessening the likelihood of unexpected problems.

[56] Studies of mergers in the American economy as a whole indicate that the results generally fall short of expectations, and that a substantial minority are outright failures. See F. Scherer, Industrial Market Structure and Economic Performance 167-74 (3d ed. 1990). I am not aware of any convincing evidence that the success rate for hospital mergers is any better than for mergers in other industries. What little evidence there is on the actual outcomes of hospital mergers is inconclusive.

[57] This might occur, for example, if the merger enables the combined hospitals to win over substantial numbers of patients from their competitors if they plow the merger's cost savings into price cuts.

PREPARED STATEMENT OF ERLING HANSEN

The Group Health Association of America, Inc. ("GHAA") appreciates the opportunity to testify before the Subcommittee. Our statement addresses the role of the antitrust laws in fostering competition on the basis of price, quality and service in the managed care environment, and, in particular, proposals to amend the antitrust laws to give protection to certain collaborative activities among health care providers.

GHAA is the national association of health maintenance organizations and similar managed care companies. Our 340 member companies provide health care to 75 percent of over the 41 million Americans enrolled in HMOs. Our member companies include both for-profit and not-for-profit organizations. Their enrolled members are broadly representative of the various age, social and income groups within their service areas. These HMOs contract with large and small employers, state and local government as well as with Medicare and Medicaid. Some health maintenance organizations operate hospitals and employ their own staff physicians. However, most HMOs contract for medical and hospital services with independent physicians, medical groups, hospitals and other health care providers.

Competition among these health care providers is essential to HMOs seeking to arrange for quality health services on a cost-effective basis. The antitrust laws, and their vigorous enforcement by the Department of Justice, Federal Trade Commission and state attorneys general, play an important role in preserving and protecting competition in health care.

HMOs provide their enrollees with comprehensive health care through networks, or panels, of health care providers. Through their contracts with physicians, hospitals and other providers, they seek to provide high quality care, while also controlling costs in order to provide comprehensive benefits at an affordable price. It is important, therefore, that HMOs be able to contract for health services without having to face boycotts, "united front" obstructions, price fixing conspiracies, "ethical" restraints on doctors' affiliating with HMOs, local provider monopolies, and other restraints of trade.

Over the years, antitrust enforcement has played an important role in helping remove obstacles facing HMOs. Antitrust cases have challenged professional society ethical rules and "self-regulation" against contracting with managed care plans,[1] denials of hospital privileges to doctors affiliated with HMOs,[2] restraints by dominant fee-for-service payors on physicians affiliating with HMOs,[3] and combinations among providers to force higher reimbursement.[4] Antitrust authorities have also challenged conspiracies to obstruct utilization review programs,[5] boycotts and other conspiracies to maintain prices or force increases in reimbursement,[6] and hospital mergers that threaten to make local hospital markets collusive or monopolistic.[7]

Antitrust enforcement has been, and under reform will continue to be, a critical resource for HMOs trying to enter new communities and to maintain or expand their presence in local markets through cost-effective and innovative programs. Some health care providers at times may form organizations for the putative purpose of facilitating or coordinating managed care contracting, but that in fact hinder or block effective managed care contracting. For example, all the OB-GYNs in a certain locale may form a "foundation" through which all HMOs must deal to obtain their collective services; OB-GYN's refuse to deal individually with any HMO, meaning no HMO can do business in this area if it cannot come to terms with the "foundation." Law enforcement authorities have brought a number of cases to pursue these types of allegations.[8]

GHAA would be greatly concerned about any proposed legislative change that would make it harder for government authorities or private plaintiffs to successfully challenge anticompetitive combinations or agreements among local health care providers, whether organized informally or through joint ventures, "networks," associations or mergers.[9] Nor does GHAA believe the antitrust laws should be changed to permit combinations of competitors designed to alter the balance or dynamics of negotiations between health care providers and health care purchasers, such as HMOs. The cause of health care reform and cost containment would not be aided by giving providers greater power or leverage in their dealings with health care payor's than would currently be permitted under the antitrust laws. Finally, while self-policing and voluntary restraints in the health care field can help achieve quality assurance and cost containment ends, the antitrust laws should not be altered to remove antitrust boundaries on self-policing by competitors. Such self-imposed restrictions can too often serve to stifle innovation, as did prior ethical restraints on physician involvement in HMOs, or establish a floor for resistance to greater cost controls. All the above types of changes would weaken the antitrust laws and over time result in higher, not lower, health care costs.

The antitrust laws have not chilled innovative and creative initiatives in managed health care. It is since the antitrust laws began being enforced regularly in the health law field in the mid-1970s that managed care has blossomed and grown. There are now innumerable and diverse variations of HMOs, preferred provider organizations, individual practice associations and physician-hospital joint ventures and health care alliances in communities across the country.

The courts and the Federal Trade Commission's rulings provide a compliance road map for health care payors and providers, and a warning to those who would violate the antitrust laws. The enforcement agencies have supplemented this record with advisory opinions, review letters, and policy statements to clarify areas of confusion and uncertainty. This type of educational activity is critical, because the health care environment changes, and new antitrust issues arise frequently. We encourage the enforcement agencies to continue this work.

We concur with others on the need for greater clarification of the enforcement agencies' views and intentions on some points. More clarification would be useful with respect to physicians and other practitioners who join together in limited numbers to contract with third party payors, where there is no danger of coercion, group boycotts, or exploitation of market power. The enforcement agencies might also confirm that provider organizations are not barred by the antitrust laws from making recommendations to managed care plans on clinical issues, quality assurance, reimbursement and other matters, so long as these communications do not involve actual price fixing or other anticompetitive agreements. We also believe there may be opportunities for cooperation among providers and with purchasers in resolving issues of community need for expensive hospital-based technologies and equipment, and achieving useful efficiencies. Clarification of government enforcement intentions in this area, and perhaps greater flexibility, may be warranted.

We are not persuaded, however, that there is a need for changes in antitrust law itself. Moreover, we oppose any legislative change that would make it harder to challenge and remedy anticompetitive concerted activities among health care providers that obstruct managed care programs or hinder managed care organizations' achieving cost containment and quality assurance objectives. Finally, we would be greatly concerned by any initiative to foster broad based community provider networks or similar undertakings if it proceeded on an assumption that competition among hospitals, physicians and other providers in dealing with HMOs or other payors could or should be sacrificed or put aside. Antitrust rightly does not put faith in cartels, benevolent or otherwise. Relaxation of the merger or other antitrust laws to permit blocks of providers in a community to join together free of antitrust scrutiny would not only poorly serve HMOs and their enrollees, but also would be a disservice to all purchasers of health care services including government, large and small employers as well as individual consumers.

We are mindful of the Subcommittee's desire at this hearing to focus on the role of the antitrust laws in promoting the objectives of health care reform. As our statement has indicated, the antitrust laws have been an important and valuable—and not an impediment—to the growth and development of HMOs and similar managed care systems. However, your press release announcing this hearing also refers to your interest in figuring out whether barriers *do* exist to the development of integrated health care networks or to lowering the cost of health care.

We would be remiss in our responsibilities if we did not inform you that other laws may pose truly significant obstacles to those objectives. High on our list are the fraud and abuse laws written to curb abuses in the Medicare and Medicaid components of the dominant fee for service, third party payor health care system. These view with disfavor any transaction where a provider is given financial incentives to refer Medicare or Medicaid patients to another provider, or where a provider grants financial concessions in order to gain access to a patient population. A payment or other renumeration to induce referral of Medicare or Medicaid services can corrupt the integrity of the provider's referral decision. This can increase cost to these programs, encourage inappropriate utilization or degrade the quality of care. Thus, the classic provider "kickback" is made illegal by the fraud and abuse statute.

For managed care arrangements, using this usual framework for analyzing "renumeration" and inducements for referral, leads to perverse results. In HMOs, unlike traditional fee for service medicine, referrals to the contracting provider are a premise of the provider's agreement to prescribed compensation and other terms. Contractual controls on referrals are not only common in HMOs, they are the very essence of the coordinated care practiced in organized, integrated health care systems. We are deeply concerned that a fraud and abuse "safe harbor" regulation recently promulgated by the Department of Health and Human Services is so narrow in its scope that it may dramatically chill development of legitimate managed care programs, rather than provide the protection from fraud and abuse prosecution it

was intended to provide. It is essential that regulations implementing the congressional mandate to issue fraud and abuse "safe harbors" provide adequate protection of both currently accepted methodology of managed care operation and foreseeable innovations that will occur as our health care system responds to the forces of reform. We urge this Subcommittee to consider additional hearings to focus on those laws as we believe they may truly impede the development of incentives for coordination and collaboration of health care services and for assuring affordable high quality health care.

ENDNOTES

1. *See American Medical Association,* 94 F.T.C. 701 (1979), *aff'd as modified,* 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided court,* 455 U.S. 676 (1982); *American Medical Association v.* United States, 317 U.S. 519 (1943); *American Society of Anesthesiologists,* 93 F.T.C. 101 (1979).

2. *See Forbes Health System Medical Staff,* 94 F.T.C. 1042 (1979); *Medical Staff of Doctors' Hospital,* 110 F.T.C. 476 (1988). *See also Medical Staff of Holy Cross Hospital,* No. C–3345 (consent order Sept. 10, 1991); *Medical Staff of Broward General Medical Center,* No. C–3344 (consent order, Sept. 10, 1991).

3. *Medical Service Corp. of Spokane County,* 88 F.T.C. 906 (1976); *Blue Cross of Washington and Alaska* v. *Kitsap Physicians Service,* 1982-1 Trade Cas. (CCH) ¶ 64,950 (W.D. Wash. 1981).

4. *Association of Independent Dentists,* 100 F.T.C. 518 (1982); *Michigan State Medical Society,* 101 F.T.C. 191 (1983); *United States* v. *Massachusetts Allergy Society,* 1992–1 Trade Cases (CCH) ¶ 69,846 (E.D.Mass 1992); *United States* v. *Alston,* 974 F.2d 1206 (9th Cir. 1992).

5. *See Indiana Federation of Dentists* v. *FTC,* 476 U.S. 447 (1986).

6. *See, e.g., United States* v. *North Dakota Hospital Association,* 640 F. Supp. 1028 (D.N.D. 1986); *Michigan State Medical Society,* 101 F.T.C. 191 (1983).

7. *See, e.g., American Medical International,* 104 F.T.C. 177 (1984); *Hospital Corporation of America,* 106 F.T.C. 455 (1985), *aff'd,* 807 F.2d 1381 (7th Cir. 1986), *cert. denied,* 481 U.S. 1038 (1987).

8. *Southbank IPA,* FTC Dkt. C–3355, 57 Fed. Reg. 2913 (consent order, January 24, 1992); *Association of Independent Dentists,* 100 F.T.C. 518 (1982); *Preferred Physicians, Inc.,* 110 F.T.C. 157 (1988) (consent order); *Maine* v. *Alliance for Healthcare, Inc.* 1991–1 Trade Cases (CCH) ¶ 69, 339 (Me. super Ct. 1991).

9. A Department of Health & Human Services task force recently concluded that no change in the antitrust laws is warranted, either on cost-containment or quality grounds, to protect mergers of competing hospitals in local markets. "Report of the Secretary's Task Force on Hospital Mergers." (February 1993)

RESPONSES OF MR. HANSEN TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question No. 1. HMOs and PPOs have witnessed a growing amount of antitrust lawsuits. What factors are fueling this growth in litigation?

Answer. There have been two basic types of antitrust lawsuits in this field. First, federal and state law enforcement authorities and managed care firms themselves have brought key antitrust cases against anticompetitive provider activities. These suits have been instrumental in protecting the rights and interests of HMOs, PPOs, and the customers they serve. Managed care organizations depend on the existence of vigorous competition among health care providers. At times, law enforcement has been necessary to ensure that monopolistic provider behavior does not obstruct access to the market for managed care. These cases have been of tremendous positive benefit to the HMO community.

Second, as managed care programs have expanded in recent years, participation in managed care programs has become more economically significant to individual providers. As a result, when providers are unable to secure a contract to participate in a managed care organization or the terms of dealing are not to their liking, some providers have resorted to antitrust litigation. These types of antitrust suits rarely succeed. They do not pose a significant problem or expense for the HMO community overall.

Question No. 2. What proportion of the members of your organization have been affected by antitrust lawsuits?

Answer. HMOs throughout the country have benefited tremendously from antitrust enforcement by state and federal authorities and by private antitrust suits challenging anticompetitive provider activities that obstruct the development of HMOs and other managed care programs, or drive up costs.

A very small number of HMOs have themselves been sued by excluded providers seeking to assure their participation in the HMO's program or by providers seeking

to challenge the HMO's terms of dealing, or making similar charges. These antitrust lawsuits are generally unsuccessful and do not pose a significant problem for the HMO community.

Question No. 2A. Of that proportion, how many covered beneficiaries would that roughly translate into?

Answer. Virtually the entire national HMO enrollment of 41.3 million has benefited from antitrust enforcement seeking to break down obstacles to HMOs and managed care. In contrast, few, if any, beneficiaries have been affected by lawsuits filed by excluded providers against HMOs, since these cases usually fail.

Question No. 2B. Has your member organizations' experience with antitrust been concentrated on situations involving the physician services part of an HMO?

Answer. Needed antitrust enforcement to remove unlawful restraints on HMOs and managed care has over the years most often been required with respect to physician activities. However, numerous cases have also involved activities by hospitals, dentists, and other health care providers.

Suits by individual providers to force their inclusion in HMO provider networks have been filed by physicians, hospitals, pharmacies, laboratories and other providers. As noted above, these cases usually fail.

Question No. 3. Given current law, what measures could be taken to minimize managed care's risk of antitrust litigation?

Answer. Managed care organizations need to operate independently and avoid participation in coercive, collusive or monopolistic schemes. They also should not give the appearance of operating arbitrarily or without regard for the effect their actions will have on providers or patients. Managed care organizations that obtain advice of competent and experienced antitrust counsel should not face difficulty carrying out legitimate business plans.

RESPONSE OF MR. HANSEN TO A QUESTION SUBMITTED BY SENATOR DURENBERGER

Question. Generally, managed care has benefited from antitrust enforcement. Would you expect a federal antitrust waiver process to threaten health maintenance organizations' viability in a reformed marketplace?

Answer. We cannot assess the impact on HMOs of an antitrust enforcement waiver process without knowing what conduct a waiver would protect, what impact a waiver would have on the availability of private antitrust lawsuits for damages or injunctions, and what showing would be required to obtain a waiver.

RESPONSES OF MR. HANSEN TO QUESTIONS SUBMITTED BY SENATOR HATCH

Question No. 1. You mention in your testimony that you concur that there needs to be greater clarification or flexibility of the antitrust laws regarding provider groups joining together "in limited numbers" for contract negotiations or for making recommendations on clinical or quality issues or reimbursement or other matters, as long as there are not abusive boycotts or actual price fixing, etc. What sorts of changes or clarifications would be acceptable?

—Would market power screens for such provider groups be acceptable?
—If so, of what size, 15%, 20%, 25%, 40% of a given market?
—Different sizes for different purposes?
—Would it make a difference if the arrangements between doctors were non-exclusive?
—Would exclusivity or non-exclusivity of provider "networks" be more acceptable?

Answer. The Group Health Association of America ("GHAA") believes that the antitrust laws have played and continue to play a critically important and beneficial role in preventing anticompetitive activities that suppress managed health care and obstruct cost containment. We believe that the antitrust laws, as currently in force, set the appropriate bounds on relations between providers and managed care plans. We do encourage the antitrust enforcement agencies to be as clear and specific as possible in articulating their enforcement priorities and views regarding the above issues, since there remains some uncertainty on the enforcement agencies' enforcement priorities and views on a few points.

One example is agreements among providers controlling a managed care network organization that might technically be viewed as "price fixing," in situations where there would appear to be no risk of competitive injury because market power is plainly lacking. Another area where the agencies could be more clear concerns discussions by provider groups with managed care plans, where the discussions do not involve any coercion, threats, or express or implied agreement on price or other terms of dealing. This uncertainty in our view is not a major problem, though. We

do not believe this uncertainty has had a material effect on the ability of health maintenance organizations to operate efficiently in the marketplace.

GHAA has not itself formulated specific views on the particular points of antitrust enforcement listed in the question. That responsibility is best left to the enforcement agencies, and ultimately to the courts. For instance, exclusivity can indeed be an aggravating factor in assessing the antitrust implications of some conduct, where the result is to foreclose others from a large portion of a market. Exclusivity in some other situations may in fact foster competition, by allowing health plans to differentiate themselves on the basis of the make-up of their provider network.

We are concerned that an effort to codify by statute what specific managed care related conduct will and will not violate the antitrust laws risks over-inclusiveness or under-inclusiveness, and also poses the danger of creating new confusion. Such an initiative would seemingly need, for example, to take into account product market definition (e.g., all physician services, or primary care physician services, including or not including pediatricians), geographic market definition (e.g., community, county, or metropolitan area), barriers to entry, the degree of concentration in the market, the impact of hospital admitting privilege patterns on physician competition, the degree to which there is express or de facto exclusivity on the part of the providers in any particular provider network organization, the degree to which providers in fact participate in other managed care organizations, and the likelihood that payors could successfully resist any attempt to impose exploitive terms of dealing.

A statute that put all these factors at issue would not appear to create additional clarity. On the other hand, if the goal is to provide providers and payors with greater certainty, then legislation that sets percentage thresholds, but leaves the parties still having to determine the product and geographic market definition, for example, may create more confusion than it eliminates, and also risk discouraging legitimate behavior in some cases, and encouraging harmful behavior in others. Similarly, legislation that qualifies any antitrust immunity or protection, with a disqualification for any conduct that on balance harms competition would not appear to provide useful guidance.

Question No. 2. If you believe that "there may be opportunities for cooperation among providers and with purchasers in resolving issues of community need for expensive hospital-based technologies and equipment, and achieving useful efficiencies," as you say in your testimony, how should such cooperative activities be shielded from antitrust attack by either the agencies, or, more importantly, by a disgruntled competitor?

Answer. The antitrust laws do not give a disgruntled competitor antitrust standing to challenge cooperative activities among its competitors that injure the complainant because of the increased efficiency or lower costs of the cooperating parties. For example, if two hospitals decide which will acquire or operate particular expensive equipment this would not give a disgruntled competitor grounds for suit. Supreme Court cases in recent years have confirmed that antitrust standing is reserved for plaintiffs who suffer injury of the sort the antitrust laws were designed to prevent, not those who suffer because others operate more efficiently. *See Atlantic Richfield Co.* v. *USA Petroleum Co.*, 495 U.S. 328 (1990); *Cargill. Inc.* v. *Monfort of Colorado. Inc.*, 479 U.S. 104 (1986); *Brunswick Corp.* v. *Pueblo Bowl-O-Mat. Inc.*, 429 U.S. 477 (1977).

Where providers cooperate with a contracting managed care organization, and establish a risk-bearing joint venture whose legitimate competitive goals and cost-containment objectives can be met through cooperation with the managed care plan in identifying services that may be reduced or shifted, we believe that the enforcement agencies should be able to assess such initiatives under the antitrust rule of reason, and approve them where they are not anticompetitive on balance.

The states may also pass legislation recognizing the value of such cooperative arrangements, and establishing a framework for their review and oversight by state regulatory officials. Where this is done, state action immunity from the federal antitrust laws can be achieved.

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

Mr. Chairman, I am glad that this hearing is taking place today. We all know that health care reform is a critical issue facing our nation and facing the Senate. We will soon receive the Administration's health care reform proposal. Members of Congress, on both sides of the aisle and in both houses are actively working on health care proposals of their own.

All proposals appear to have a common goal: to reduce the health care cost growth rate and get rid of excess capacity and inappropriate resource allocation. Most comprehensive health care reform plans will restructure the health care delivery system. This restructuring will result in health care market consolidation.

The prospect of such consolidation raises questions about antitrust applications, and I believe it is time for us to begin thinking about the antitrust laws and policies that may need to be changed if health care reform is to be successful. We should begin by identifying potential antitrust risks that the health care delivery and insurance systems would face if the proposed organizational changes to the way we purchase and deliver health care were instituted without special legislative protection.

I ask the witnesses to consider the purpose of the hearing: the relationship between antitrust policy and health care reform. Remember that the goal of comprehensive health care reform is to increase the access to care, maintain the quality of care, and reduce the growth rate of the cost of care.

I anticipate that in this discussion the witnesses will tell us what they believe is good about today's antitrust enforcement approach as well as what problems exist.

I know that in the State of Utah, the taxpayers and the medical community have spent millions and millions of dollars providing documents, explaining actions, and defending against federal antitrust investigations. Dollars that should have been spent on preventing and treating disease have been spent on lawyers. This seems ludicrous at a time when all Americans are focused on trying to reform the health care system and on preventing inappropriate allocation of scare resources.

This is clearly an example of antitrust application that is detrimental to the efficient delivery of health care; and, in the process of considering comprehensive health reform that will affect every American in the future, we must not fail to address the relationship of health care reform and its relationship to antitrust policy.

It is easy to point fingers at who should be blamed for rising health care costs. Indeed, some attack the private sector for charging "high" prices for innovative life saving medicines and treatments; they believe these drugs and treatments should be sold for less money. However, innovative research is costly and complex equipment is expensive. It needs to be paid for.

Without incentives to innovate, many of the therapies we now have would not exist, and patients would have to suffer more or even die. Americans live longer thanks, in part, to the power of our innovative and sometimes expensive new medicines and medical technology. Increasing health care costs will continue to correlate with human longevity and development of innovative technology and therapies.

Charges can also be made that government is a significant part of the problem because of reimbursement policies, slow approval of new drugs and devices, burdensome insurance mandates, excessive paperwork, and excessive regulatory policies. The health care industry is probably the most regulated U.S. industry today. In reviewing our health care system, we need to address systemic problems and to avoid needless blame.

We must address the unnecessary causes of overly costly services or products. Most Americans, for example, understand the extra costs that defensive medicine and the threat of malpractice impose on health care. However, the hidden costs of other systemic problems such as those posed by unrealistic or inappropriate antitrust policy are less obvious.

Consumers realize when their local community has more hospitals than seem necessary, operating with empty beds, or when the locality has more than one expensive health care service center, such as a trauma center or medivac helicopter service. They realize that one service would work better and at less cost. Indeed, the many proposals now under discussion for "managed competition" are a recognition of the need for greater efficiency in the amount, allocation, and use of resources devoted to health care.

The American health care system is unique in several ways. First, it is highly regulated. Second, most Americans have some sort of health insurance leaving them indifferent to the price of health care except at the margin. And, third, accompanying this indifference to price is a nearly limitless demand for services. Many argue that the health care market has become increasingly dysfunctional over time and that its many unique features interfere with the supply and demand functions associated with truly free markets.

In order to increase access and maintain quality, some health care providers have sought to increase efficiency by collaborating in order to reduce overcapacity and to eliminate duplication of services or equipment. Others wish to set up regional networks of services. Yet, I have heard serious complaints about our own government discouraging such efforts. The activities of our Department of Justice and Federal

Trade Commission have been said to have a very chilling effect on efforts to achieve efficiency.

For example, providers of health care are afraid that if they even meet once to discuss more efficient arrangements for health care delivery, they could become the target of an antitrust investigation or enforcement proceeding. Although such charges do not always stick, they always have to be defended at substantial cost and always have uncertain outcomes.

As we look toward health care reform, we need to examine the role of government in health care and to make sure that the government's role is part of the solution and not part of the problem. Over the last fifty years, the government has exercised an increasingly greater role in all aspects of the health care system from fundamental biomedical research to access to disease prevention and treatment. For example, the federal government stimulated and paid for a substantial portion of our current excess capacity of hospital beds. Almost half of all U.S. health care costs are paid for by the federal government.

Today the government is the dominant force in U.S. health care, both in setting standards for services and products and in paying for them. The fact that the federal government plays such an overwhelming role in health care is another reason that health care may not fit easily into free market economic models typically used in antitrust enforcement in other areas.

Invariably, health care reform will include reform of antitrust policy and laws to allow more rapid health care market consolidation and conservation of health care resources to increase access and efficiency. In some situations expensive excess capacities need to be reduced; in others, particularly in rural America, resources need to be shared in order to become more available.

Managed competition is one reform model receiving widespread attention. It involves a policy that encourages health care market consolidation through the establishment of managed care networks called Accountable Health Plans or AHPs. The AHPs would have some of the same characteristics as health care maintenance organizations of today—a combination of provider networks with an insurance function. Managed competition also creates entities with substantial purchasing power through the pooling of individuals and employees of small businesses into very large groups called Health Plan Purchasing Cooperatives or HPPCs.

I will ask the witnesses to consider what additional risks to antitrust enforcement they think these players, that is the AHPs and HPPCs, and drug, device and other technology manufacturers might be exposed to if such reforms were enacted.

We cannot craft the necessary changes to the antitrust law until we have answered certain policy questions. Questions such as who will own and govern the large purchasing groups and what, if any, statutory restraints will be placed on their ability to exclude managed care networks? Should we allow the large purchasing groups to develop monopsony power in an area? What would be the result? What difficulties would the health care networks face in terms of their development? How do we ensure that provider networks do not charge monopolistic prices in an area where they are the sole provider?

"Managing competition" through the creation of very large group purchasers and managed care networks is described as having the potential of increasing "true competition." We need to be able to determine the net effect of combining a monopoly provider of services with a monopsonistic purchaser in a given market area.

Many proposals contain the concept of provider network development. Many proposals result in the pooling of purchasing power. The fundamental question is: without statutory protection will our antitrust policy allow health care reform to flourish or will it cause health care reform to be stymied and wither before it has a real chance to work?

I would like to mention in closing that, in my view, the most effective health care reform will be that which encourages the maximum reliance on individual initiative and helps to develop an effectively functioning market for American health care. Thus, I would urge that we consider reforms to antitrust that will actually strengthen our competitive system.

PREPARED STATEMENT OF BEVERLY L. MALONE

Mr. Chairman, I am Beverly L. Malone, PhD, RN, FAAN, I appear today on behalf of the American Nurses Association (ANA) and its 53 state and territorial associations. The ANA represents the nation's two million registered nurses including nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists. I am a clinical nurse specialist and licensed clinical

psychologist and have practiced individual, group and family psychotherapy for over 19 years.

Mr. Chairman we are pleased that you are holding this hearing on antitrust issues in the health care industry. We share your observation that "we can no longer afford the inefficiencies of duplication or financial incentives that encourage technology at the expense of prevention." Nursing believes that consumers have a right to affordable quality health care. Nurses support the coordination and collaboration of health care services and believe that multi-disciplinary provision of preventative and primary care services is cost-effective.

As the nation prepares for health care reform, nursing is convinced that we should not repeat the existing delivery, financing and workforce problems. The health care reform bill must address the restrictions on health care providers that occur at both the federal and state level which limit access to care.

We are also concerned that some providers are using the unknown sphere of health care reform to push for antitrust changes. The focus on cost containment should not be used as an argument to remove protections against antitrust which promote pro consumer health care practices.

Increasingly, much of the policy debate about the future directions of health care in America is focusing on new ways to use the forces of the marketplace and the pressures of price competition to constrain rising health care costs. In the public sector, governments at every level, concerned with budgetary problems, are taking various steps to gain improved control over public spending for health. These steps include fundamental changes in the methods used by governments to pay for health services provided to the aged, the disabled and the poor. Governments are also attempting to encourage wider use of alternatives to the traditional ways of delivering such services in the community. In the private economy, too, there is growing interest on the part of employers and others about new ways to use the marketplace as an effective instrument for achieving the goal of a more efficient health delivery system. In many parts of the country, the pressures of increasing competition within the health care industry are already being felt.

The President's Health Care Reform Task Force has focused on managed competition. Conceptually we agree that increased competition would be beneficial to the health care system. Yet one paradox regarding competition is that the general rules of the game have to be established and enforced in order to assure that all competitors will have the opportunity to compete. Indeed nurses can compete but the playing field must be level. Any competitive market requires monitoring and intervention from time to time to guarantee that competition is open and fair.

We believe that antitrust enforcement offers an excellent opportunity to counterbalance the potential of monopoly power through scrutiny of such activities as barriers to entry into particular markets, territorial or market restrictions, economic boycotts, price fixing, tying the purchase of one service to another, and restricting the flow of truthful information between buyers and sellers. It seems unlikely that health care providers, let alone consumers, would be protected from the adverse consequences of such activities if the antitrust laws were not applied to the professions. The Federal Trade Commission (FTC) has been fulfilling this necessary role for some time, and the movement toward increased competition makes their proactive presence even more critical, if inflationary pressures in the health care market are to be relieved in a fair and equitable manner.

Anti-competitive barriers must be removed to allow nurses and other qualified non physician providers to provide health care services within their professional capacity. These barriers include unnecessary nursing practice act restrictions, over regulation of non-physician providers, unnecessary limitations on prescriptive authority, and lack of third party reimbursement by public and private payors.

BACKGROUND

Throughout this testimony we will refer to advanced practice nurses (APNs), which includes nurse practitioners, certified nurse midwives, clinical nurse specialists and nurse anesthetists. Registered nurses, are educated to provide high tech care in the acute care setting, primary care in the ambulatory setting and to coordinate and to manage care in both. APNs are nurses who have acquired the additional education necessary to provide a full range of health care services. The nursing profession has established additional educational requirements, along with certification, for APNs. APNs, like all nurses, emphasize health promotion and disease prevention. As primary health care providers, their functions include: health assessment, physical examination, development of a plan of care, instruction and counseling, use of laboratory data, diagnosis of routine illness, prescription of medications or other

therapies as allowed by state laws, coordination of services, and referral when necessary. APNs do not practice medicine.

Nurse practitioners (NPs) are registered nurses with advanced education (approximately 50 percent are educated at the master's level) in advanced nursing and primary care. The NP performs physical exams, treats acute and chronic illness and provides routine care to children, adults and the elderly. Of the approximately 30,000, NPs 67 percent practice in ambulatory settings and 27 percent in hospital settings (Division of Nursing, 1988).

Clinical nurse specialists (CNSs) are registered nurses with a master's degree in a clinical area of nursing. CNSs also conduct physical exams, treat acute and chronic illness and provide routine care. They specialize in a variety of areas including medicine, surgery, psychiatry, cardiac rehabilitation, gerontology, trauma and diabetes. Of the approximately 40,000 CNSs, 25 percent practice in the ambulatory setting and 71 percent practice in hospitals (Division of Nursing, 1988).

Certified registered nurse anesthetists (CRNAs) are registered nurses who have completed two to three years additional education beyond the bachelor's degree. CRNAs administer more than 65 percent of all anesthetics given to patients each year and are the sole providers of anesthetics in 85 percent of rural hospitals. CRNAs provide anesthesia in a variety of settings—operating rooms, dentists' offices, and ambulatory surgical settings. These nurses frequently provide anesthesia independently in these settings without the supervision of the physician. There are approximately 25,000 CRNAs.

Certffied nurse midwives (CNMs) are nurses with an average of one and one-half years of specialized education beyond nursing school, either in an accredited certificate program, or increasing at the master's level. They provide prenatal and gynecological care, conduct deliveries and follow mothers post-partum. In 1988, CNMs delivered 115,000 infants or 3.4 percent of all U.S. births. There are approximately 5,000 CNMs.

Third-party payers have become increasingly aware of the cost-effectiveness of APN services as indicated by their willingness to cover their services. APN services are covered in some degree by: Medicare, Medicaid, Civilian Health and Medical Programs of the Uniformed Services (CHAMPUS), the Federal Employees Health Benefit Program (FEHBP), and private insurance companies in some states. Thirty-seven states have adopted legislation enabling third party reimbursement for the services of specified categories of nurses.

FEDERAL PROGRAMS

Translating the goal of health care provider choice legislation into reality at the Federal and State levels has been a slow and incremental process. Nevertheless, as the two attached tables indicate, nurses in advanced practice have increasingly become eligible for direct reimbursement for their services under Federal health benefit programs—Medicare, Medicaid, CHAMPUS and FEHBP (Table 1)—as well as through State mandates (Table 2).

Congress recently approved changes in three Federal health programs that recognize NPs, CNS, and CNMs as independent providers. The Omnibus Budget Reconciliation Act (OBBA) of 1989 mandated direct reimbursement to pediatric nurse practitioners and family nurse practitioners under the Medicaid program. The OBRA provides for direct Medicare reimbursement of NPs and CNSs who serve in rural areas. Also passed by Congress in 1990 was a provision requiring the reimbursement for services performed by NPs, CNSs and CNMs in all FEHBP programs for covered services.

Despite the recent changes in Federal and State reimbursement laws, there are still enormous changes that must be made. For example, in order to improve access to care to Medicaid certain reforms in payment and coverage policy need to be considered. Currently, the Medicaid program mandates the coverage and payment of nursemidwifery, certified pediatric nurse practitioners and certified family nurse practitioners but does not mandate the coverage of all nurse practitioner, clinical nurse specialist and certified registered nurse anesthetist services. The Medicaid program needs to directly reimburse for the services of these practitioners in order to encourage the utilization of these providers.

Several states have changed their State Medicaid payment and coverage policies to encourage the use of these practitioners and have been able to increase access to care for vulnerable populations. In New Hampshire, the services of NPs are covered by Medicaid and access to care is improved. Many physicians have a limit on the number of Medicaid patients they will accept in their practice and refer additional Medicaid beneficiaries to NPs who see them in their own practice or through well-child and pre-natal clinics. Some NPs in New Hampshire have a caseload that

is 90 percent Medicaid. The State's Medicaid payment policy also encourages the use of these practitioners. Since 1982, NPs have had their services covered by the Medicaid program at 100 percent of the physician rate. According to Charles Albano, Chief, Bureau of Maternal and Child Health in New Hampshire, NPs are relied upon to provide the vast majority of services to low income women, 75 percent of whom are Medicaid recipients, NPs are also utilized to staff the family planning clinics and the well child services in the state.

Anne Sorley, Maternal Service Program Manager of Medical Assistance, reports that in 1989 Washington State established a First Step Program that consisted of ten alternative clinics. All but one is served by CNMs and NPs, who provide the majority of care. These clinics serve the poor and working poor with incomes up to 185 percent of the poverty level. The utilization of these services is evidenced by the 100 percent increase in deliveries in one of the clinics in the second year. The success of the clinics, according to Ms. Sorley, is partly attributed to the style of practice of the CNMs. CNMs are more willing to provide services to substance abusing women and are willing to offer flexible schedules to increase the number of prenatal visits. Also the phenomena of women treating women adds to patient compliance.

Medicaid payment policy also needs to be improved to increase access to care. Payments to nurses in advanced practice under the Medicaid program needs to be based on the service and not on the type of provider. This policy in New Hampshire provides a positive incentive for pre-natal and well child clinics to use NPs. Washington State has adopted a similar policy of payment based on the service and also increased the payment for the services. The State established a delivery system and changed its Medicaid fee schedule to improve access to care to pregnant women.

Washington also changed the Medicaid fee schedule to improve access to care. In 1989, the Legislature added $200—$300 to the obstetrical package to offset malpractice costs and to improve recruitment of providers. In 1990, the policy was established to pay all providers the same rate for the same services. This had a significant effect on recruiting NPs and CNMs. There is no nurse midwifery educational program in the State, yet *the improved competitive fees were instrumental* in bringing these practitioners into the State to staff the clinics. In two years, the number of CNMs increased by 33 percent and there has been a limited turnover of CNMs, despite their serving a high risk population.

Senator Tom Daschle (D–SD) has introduced legislation (S. 466) that would improve access to the services of NPs and CNSs. It would mandate the coverage and payment of all NP and CNS services under the Medicaid program. An identical bill (H.R. 1683) has been introduced by Representative Bill Richardson (D–NM). ANA strongly supports this legislative initiative.

We also need to remove barriers to health care for our nation's elderly. ANA was pleased to have the opportunity to work closely with Members of this Committee and the House Ways and Means and Energy and Commerce Committee to achieve enactment of the "Rural Nursing Incentive Act." That proposal, which was included in the OMRA (Public Law 101–508), allows NPs and CNSs who practice in rural areas to receive direct reimbursement under Medicare. That law now needs to be expanded to cover the services of all NPs and CNS regardless of geographic location and practice setting. This expansion of coverage does not provide for reimbursement for new services, but rather provides for reimbursement for existing services in alternative cost-effective settings by non-physician providers. In addition, modeled after the bonus payment of physicians who work in health professional shortage areas (HPSAs), these practitioners would also be paid a bonus payment when they work in HPSAs. By taking this action, these advanced practice nurses would provide essential services to meet the health care needs of those older Americans who currently have no access to affordable health care. In that regard, a bill (S. 833) to provide direct Medicare reimbursement to NPs, CNSs and CNMs was introduced on April 28 by Senators Charles Grassley (R–IA) and Kent Conrad (D–ND).

ANTI-COMPETITIVE PRACTICES

There are many other barriers to nursing practice which have been imposed over the years through regulation, legislation or custom which not only limit the scope of nursing but also effectively impede the ability of the nurse to compete.

- **Use of practice arrangements to limit the activity of nurses in advance practice.** Some states mandate that the physician maintain a hands-on supervisory relationship, while other states allow the nurse in advance practice to practice independently and unencumbered. Nursing is advocating for consistency to ensure that APNs can maintain an independent practice within the scope of his/her education and preparation in all 50 states.

- **Inconsistency in definitions of advanced practice.** The laws vary from state to state on who may be considered a nurse in advanced practice. The most glaring example of such inconsistency is the treatment of the clinical nurse specialist. In states where advanced practice is recognized, the law is not consistent on the treatment of the CNS. This inconsistency limits the use of all nurses who have properly received graduate education and/or preparation to provide advanced nursing services.
- **Scope of practice varies from state to state and does not reflect the education and clinical expertise of the nurse in advanced practice.** All state nurse practice acts have not been amended to reflect current education and clinical expertise of the nurse, particularly APNs. Others use medical practice language to limit the nurse's practice by allowing medical practitioners to determine the boundaries of nursing practice.

These have also been limitations placed on advanced practice nursing when nursing attempts to expand the scope and responsibility of the nurse in advanced practice.

- **Prescriptive authority has been limited through the use of protocols and requirements for supervision and physician intervention in this nursing activity.** Like other aspects of nursing practice, prescriptive authority has occurred only after nursing has taken affirmative action to enact laws on the subject. First, prescriptive authority is not universal or consistent. There are approximately 36 states which have some form of prescriptive authority.
- **Use of Medical Practice Act to limit scope of nurse through expansive scopes that include virtually every health care action as a "delegated medical function."** Many states' medical practice act define medical practice to incorporate every aspect of medical care and then limit the actions of other health care professionals to those acts "delegated" by the physician. This sweeping legislative language has been used to limit the ability of APNs.

THIRD PARTY PAYOR POLICIES

Barriers also exist in the provision of insurance coverage.

- **Limitations on the availability and accessibility of liability coverage.** During the 1980's tort reform crisis, the number of reinsurers willing to provide coverage for insurers writing nurse liability coverage dropped dramatically, with many claiming nurse malpractice had increased. When asked about specific actuarial data, none could provide it. (See Table 3).

Property Casualty Insurance Edition 1988 reports that

> At one time, nurse-midwives, were not segregated from the rest of the nursing field by underwriters of nurses' professional liability insurance. Premiums for nurses' malpractice insurance were so low that the main problem faced by underwriters was the expense of issuing policies rather than the cost of incurred losses.
>
> As the experience of this class developed, underwriters segregated the experience of nurse-midwives and CRNAs (certified registered nurse anesthetists) and became less willing to underwrite these providers. At the same time, demand for the services of these nurses increased, and specialized training and certification requirements became more stringent.
>
> Losses for nurse-midwives' liability cases did not increase dramatically, primarily due to limited patient load, screening procedures and loss control methods. However, two carriers providing professional liability insurance dropped their programs. The dramatic increase in the frequency and severity of claims against physicians and hospitals because of poor obstetrical results discouraged the commercial insurance marketplace from providing replacement coverage for nurse-midwives.

- **Use of insurance surcharges to increase malpractice premium coverage and provide impediments to physician-nurse collaboration.** Insurance companies also charge additional premiums of physicians who are in collaborative practices with APNs. These amounts are often hard to trace because they are incorporated into general increases and often are not treated as a separate charge. The surcharges, are allegedly based on the increased risk physicians incur for collaborative practice—and can be easily traced in collaborative arrangements with nurse anesthetists and nurse midwives.

Nursing believes that any action which restricts the provision of health care services when there is a demonstrated need and demand is without merit and unjustified. It is inconsistent with the present call for health care marketplace competition

to decrease costs and to increase access to care with demonstrated positive outcomes.

There are clear instances of anti-competitive actions still occurring in various states.

- **Provider actions restrict nurses participation in professional groups, liability programs and marketplace.** There is only one State where a nurse sits on a Health Maintenance Organization (HMO) board. Such policies results in one practitioner domination of practice and restricts provider access to the marketplace.

In Tennessee two nurses midwives filed suit against the Nashville Hospitals, five doctors and an insurance company. The nurses were not allowed privileges or appropriate reimbursement for their services, because nurse midwifery was not regulated by title through the nurse practice act or medical practice act. The lower court held that the practice of nurse midwifery was indeed nursing and privileges could not be denied because the specialty was not specifically regulated.

In the State of Alabama one practitioner reports that one month after she began practice with a physician, he informed her that his insurance carrier sponsored by the State Medical Association would no longer insure him if he continued to act as her off site preceptor. The restrictive and apparently non actuarial based policy also affects nurse midwives who cannot deliver babies without a supervising physician. It also affects NPs who would be able to practice in rural areas serving medicare beneficiaries. Only seven percent of Alabama physicians are in rural practice. This has limited the number of providers to rural residents to 18 NPs who have preceptors insured by other companies. Other nurse practitioners report that their patients have been intimidated by physicians who threaten not to see them again if the patients continue to consult nurse practitioners.

From Minnesota, a nurse practitioner reports she was not hired by a clinic because it believed she would be competitive with the physicians. Unable to provide services as a nurse practitioner in that rural area, that advanced practice nurse is working in an acute care facility. Nurse midwives in the Twin Cities area report that when their clinic acquired a new physician partner the nurse midwives were laid off. Reportedly patient preference for the midwives initiated the action.

Such actions deny access to care to vulnerable populations. Nursing and our patients can only believe that the policies are not based on actuarial evidence or outcomes research and certainly are not pursuant to the states' practice parameters. These incidents discourage integrated, coordinated, collaborative care delivery and foster costly and unnecessary duplication and gatekeeper functions.

Still other actions may not be so clearly culpable. Governmental actions may also result in anti competitive policies. Although such actions may be based on failure to understand the full range of professional health care practice, education and delivery of services, the result is the same—promotion or federalizing of anti competitive policy.

MEDICAID AND MEDICARE

Such an example is the past Administration's Federal Register publication on January 19, 1993 of the Health Care Financing Administration's final rule "Medicare, Medicaid and CLIA Programs: Regulations Implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Clinical Laboratory "Act Program Fee Collections." The rule establishes restrictions on non-physician providers and a strict interpretation of the waived criteria for classifying tests, especially the physician performed microscopy category effectively restricts the practice of APNs.

Those services are delivered in a variety of settings including physicians offices and nurse run clinics. Subjecting these providers of primary care and obstetrical and gynecological services to the restrictions outlined in the regulations has an adverse impact on patient access to basic laboratory tests and increases costs. In rural and other underserved areas these limitations on testing further compromise the health care delivery to vulnerable populations.

RECOMMENDATIONS

ANA believes that expanding the health care provider of choice principle to include all qualified health care providers must occur in public and private plans to improve access to quality health care.

Nursing believes that several actions can be taken immediately:

(1) Amend Medicare—Broaden the coverage of the services of nurses advanced practice, by amending Medicare as proposed in S. 833 outlined above.

(2) Amend Medicaid—Broaden the coverage of the services of nurses in advanced practice under Medicaid as proposed in S. 466 and H.R. 1683 as outlined above.

(3) Amend Federal health programs—Make all federal health insurance programs, including Medicare and Medicaid, CHAMPUS and FEHBP consistent with coverage of services and choice of providers. We would also recommend the advanced practice nurses also be included under the definition of acceptable medical source under 20 CFR 404, 1513 used by the Social Security Administration in its determination of disability.

(4) Strengthen implementation of federal reimbursement policy—FEHBP, Medicare and Medicaid should issue immediate clarification of current regulations and directives to all contracting carriers/insurers. Failure to comply with payment to qualified providers for services should affect eligibility to participate as a contracting carrier.

In addition to the above recommendations there are two options that can be included in the health care reform bill to remove anti competitive policies and practice barriers and to increase access to care. The options are: (1) anti-discrimination language related to benefits, services and reimbursement covered by payors and (2) incentives to encourage states' legal recognition of advanced practice nurses as qualified providers.

Option I

The use of anti-discrimination language maintains autonomy of state authority over licensure but will permit licensed advanced practice nurses and other professionals to practice within their lawful scope of practice while prohibiting discriminatory and restrictive payor practices in coverage and reimbursement.

Specific Language

"Nothing in this act shall be construed to permit a participating health benefit plan or purchasing cooperative to deny any licensed health care provider (or type, or class, or category of health care provider) practicing within their lawful scope of practice from inclusion as a qualified provider and receiving the identified reimbursement for all health related services covered by the plan or to prohibit their provision of benefits for the items and services described in the plan."

Option II

Strong incentives (financial) should encourage states to pursue amendments to regulatory and legislative language which would result in the most expansive practice parameters to allow licensed advanced practice nurses to practice commensurate with recognized professional standards. Receipt of federal funds could be tied to expansive nursing practice parameters and reimbursement statutes/regulations. At a minimum this would permit direct reimbursement.

Specific Language

"Any state which receives federal money for health care or related services must demonstrate that it has in place the most expansive practice language which recognizes licensed advanced practice nurses through professional criteria and certification. Such funding will apply to but are not limited to: block grants for health services and education programs, immunizations, sexually transmitted diseases and family planning, health prevention, substance abuse, and Ryan White AIDS Care funds."

CONCLUSION

Mr. Chairman, we commend the Subcommittee for holding this hearing and attempting to find solutions to improving access to health care. We appreciate this opportunity to share our views with you and look forward to continuing to work with you as comprehensive health care reform is developed. Thank you very much.

TABLE 1.—CURRENT DIRECT FEDERAL REIMBURSEMENT FOR NURSING SERVICES

	TYPE OF PROVIDER				
Payer	RN	NP	CNM	CRNA	CNS
Medicare:					
Part A	No	No	No	No	No
Part B	No	Rural areas	Yes	Yes	Rural areas
Medicaid	[1]State option	Pediatric and	Yes	[1]State option discretion	[1]State option discretion

TABLE 1.—CURRENT DIRECT FEDERAL REIMBURSEMENT FOR NURSING SERVICES—Continued

Payer	TYPE OF PROVIDER				
	RN	NP	CNM	CRNA	CNS
CHAMPUS	No	Yes	Yes	No	Yes
FEHBP	Medically underserved areas	Yes	Yes	Yes	Yes

[1] Approval for reimbursement is an option reserved for determination in each state's Medicaid program.

Source: American Nurses Association, Division of Congressional and Agency Relations, 1991

KEY:
RN—Registered Nurse
NP—Nurse Practitioner
CNS—Clinical Nurse Specialist
CNM—Certified House Midwife
CRNA—Certified Registered Nurse Anesthetist

TABLE 2.—STATES MANDATING PRIVATE INSURANCE COVERAGE FOR NURSES

States	All RNs	NPs	Psychiatric Nurses	CNS
AL				
AK		X		
AZ		X		
AR				
CA			X	
CO	X		X	
CT		X	X	
DE		X		
FL				
GA				
HI				
ID				
IL				
IN				
IA	X			
KS		X		
KY				X
LA				
ME				
MD		X	X	
MA			X	
MI				
MN		X		X
MS	X			
MO				
MT	X			
NE				
NV	X			
NH		X		
NJ	X			
NM				
NY	X			
NC				
ND	X	X	X	
OH				
OK				
OR		X		
PA	X	X		X
RI		X		X
SC				
SD		X		
TN				
TX				
UT	X	X	X	
VT				
VA			X	X

TABLE 2.—STATES MANDATING PRIVATE INSURANCE COVERAGE FOR NURSES—Continued

States	All RNs	NPs	Psychiatric Nurses	CNS
WA	X	X		
WV	X	X		
WI				
WY				
DC				

RN = registered nurse
NP = nurse practitioner
CNS = clinical nurse specialist

Adapted from: Blue Cross and Blue Shield Issue Brief: State Mandated Health Insurance Laws, September 1990. Updated 1991, ANA, Division of Governmental Affairs.

TABLE 3.—MALPRACTICE PAYMENTS 9/90–2/92

Practitioner (NPDB field of license category)	Number of malpractice payments reported to the NPDB [1]	Percent of all malpractice reported to the NPDB [1]	Number of active practitioners [2 3]	Number of malpractice payments per 1,000 practitioners
Allopathic	16,787	75	521,780	32.2
Osteopathic Physicians	988	4	22,810	43.3
Sub-Totals	17,775	70	544,490	32.6
Registered Nurse	334	1	1,582,816	.2
Nurse Anesthetist	112	0	16,831	6.7
Nurse Midwife	16	0	2,886	5.5
Nurse Practitioner	20	0	20,649	1.0
Sub-Totals	482	1	1,627,000	.3

[1] National Practitioner Data Bank (NPDB) data 9/90-2/13/92
[2] Seventh Report to President and Congress on the Status of Health Personnel in the United States (physician data)
[3] Findings from the Registered Nurse Population, National Sample Survey of Registered Nurses, March 1988 (nurse data)

RESPONSES OF DR. MALONE TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

1. **Nurses and other allied health providers increasingly compete with physicians to fulfill a patient's needs. Has any of this competition reduced the quality of care delivered to patients?**

ANA firmly believes that competition between registered nurses and physicians has not served to reduce quality of care and further believes that eliminating or reducing barriers to competition would serve to enhance quality. Nurses who provide primary care and other services which may bring them into competition with physicians are well prepared to provide those services by virtue of their licensure, advanced education and training. Studies of patient satisfaction and patient outcomes have found that the quality of care delivered by advanced practice nurses compares favorably to that provided by physicians. Nursing research and literature is replete with such findings, many of which are compiled and discussed in *A Meta-Analysis of Process of Care, Clinical Outcomes and Cost-Effectiveness of Nurses in Primary Care Roles: Nurse Practitioners and Nurse-Midwives*, a publication prepared by ANA. (Some studies reaching similar conclusions may be found in medical literature as well.) Federal studies which address quality of care and patient satisfaction with services provided by advanced practice nurses include a 1986 study by the Office of Technology Assessment and two recent studies by the Office of Inspector General of the Department of Health and Human Services, entitled *Enhancing the Utilization of Nonphysician Health Care Providers* and *Enhancing the Utilization of Nonphysician Health Care Providers: Three Case Studies*.

Rather than reducing the quality of care, we believe that competition among classes of health care professionals can serve to increase quality. It provides the consumer with a choice of professionals. ANA is convinced that many more consumers would choose to receive primary care from nurse providers if they were not prevented from doing so by anticompetitive practices and barriers to nursing practice. A recent Gallup Poll, for instance, found that 86% percent of consumers are either "very willing" or "willing" to receive their basic health services from an advanced practice nurse. Free competition among health care professionals would enhance consumer choice. It could also bring the salutary effect of spurring different classes of health professionals to evaluate the factors in each others' practice patterns that lead to increased consumer satisfaction and patient outcomes.

We believe that quality of patient care *is* adversely effected by anticompetitive practices which serve to hinder the availability of nurse providers. These practices have reduced access to health care services in many areas. It has also deprived many patients of services in which advanced practice nurses have considerable preparation and expertise--such as health counseling, assessment and preventive care. This anticompetitive atmosphere limits consumer choice. It also leads to increased prices since consumers are effectively prevented from choosing advanced practice nurses as a lower-cost, high-quality providers of care.

2. **Has the ANA or other health providers been accused of violating antitrust laws?**

The ANA has not been charged with any violations of antitrust law, nor are we aware of any nursing organization that has been accused of violating federal or state antitrust laws. We are aware of two instances in which federal intervention has occurred with other nonphysician health providers. One of these involves podiatry. See Federal Trade Commission Staff Letter to American Podiatry Association (August 18, 1983). Also, activities of pharmacies and pharmacists have been reviewed by federal and state law enforcement agencies on various occasions. Among the activities reviewed have been failure to acknowledge or fill mail-order pharmacy prescriptions and attempts to coerce others from participating in a state-sponsored prescription program in order to coerce the state to increase payments. See In Re Chain Pharmacy Association of New York, Federal Trade Commission Docket No. 9227 (May 1, 1992).

3. **Most of antitrust litigation involving non-physician health care providers surrounds issues related to credentialing, access to health care in an institution, and third party reimbursement. All of these activities are considered per se violations of antitrust law. Are there any other situations involving non-physician health care providers in an antitrust dispute?**

There are several circumstances affecting nursing which are not per se violations of the Sherman Act. As noted in Oltz v. St. Peter's Community Hospital, group boycotts or concerted refusals to deal constitute per se categories; however, the courts are hesitant to apply the boycott per se rule to an arrangement where the economic impact of that arrangement is not obvious. 861 F.2d 1440, 1445 (9th Cir. 1988). Likewise, it has been suggested that group boycotts ("straddle[ ] the per se and rule of reason approaches."[1] With the precedent established by Arizona v. Maricopa County Medical Society[2], Northwest Stationers v. Pacific Stationery[3] and Oltz[4], the courts have specifically narrowed the application of the per se rule.

The facts underlying Nurse Midwifery Associates v. B.K. Hibbett, 918 F.2d 605 (6th Cir. 1990, cert. denied, __U.S.__, 112 S.Ct. 406, 1991) provide a clear example of how other health care providers collaborate to limit the ability of the nurse to compete with physicians. In this case, two nurse midwives formed a joint nurse midwifery practice, procured the services of an obstetrician to provide medical collaboration, received privileges at a local hospitals and applied for privileges at other area hospitals. They found that physicians at these hospitals refused to grant privileges to them; pediatricians at the hospital where they had initially been granted privileges stated that they would refuse to provide care for newborns delivered by the nurse-midwives; and the collaborating physician's malpractice carrier cancelled his insurance policy because of his collaborative arrangement with the nurse-midwives.

While the court in this instance did not find a violation of the Sherman Act or state antitrust laws by other defendants, the malpractice carrier's decision to cancel the collaborating physician's policy was deemed to fall within the group boycott exception to McCarran-Ferguson antitrust immunity for the insurance industry.

In Washington State, nurses have documented the activities of one preferred provider organization which refuses to refer psychiatric patients in need of medication to psychiatric/mental health clinical nurse specialists, even though these providers are authorized to prescribe medication in that state. This is typical of many managed care entities around the country which exclude or otherwise discriminate against advanced practice nurses.

Many nurse midwives and certified registered nurse anesthetists have complained about the use of insurance surcharges to increase the malpractice premiums of physicians who collaborate with advanced practice nurses--which serves to drive many physicians away from such collaborative practice arrangements. Usually, cases arising from such complaints are

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[1] Alex M. Clarke, "Access to Hospitals by Allied Health Practitioners," presented before the National Health Lawyers Association: Seminar on the Changing Medical Staff, October 1992 at 11.

[2] 457 U.S. 332, 343 (1982).

[3] 472 U.S. 284 (1985).

[4] Supra.

settled out of court. In an instance in which a case was brought before an insurance commissioner for review, the commissioner found that such a premium increase had no actuarial basis. In the matter of National Capital Reciprocal Insurance Company 1991 Rate Filing (District of Columbia, Order 92-7A, February 7, 1992).

There are a number of other anticompetitive practices which are increasingly being brought to our attention. We are concerned, for instance, by the trend of permitting only pharmacists and physicians to participate in state Drug Utilization Review (DUR) panels, which oversee and make recommendations to educate prescribers and pharmacists and to identify and reduce the frequency of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among prescribers, pharmacists and patients. Excluding nurses from participation in these panels--even in states where nurses are authorized to prescribe--is problematic, particularly in view of the fact that prescribing patterns often differ between physicians and advanced practice nurses.

We are aware of other instances where anticompetitive actions have led to the inability of nurses to provide care. For instance, we have recently learned of refusals by physical therapists to accept orders for care of patients of advanced practice nurses. Many pharmacists have refused to fill prescriptions written by advanced practice nurses, even where these nurses are authorized to write prescriptions. Some mail order pharmacies have also refused to fill prescriptions written by nurses. These types of restraints may be considered group boycotts which limit the ability of the nurse to obtain the necessary "tools" of the profession. Instead of horizontal arrangements, these practices appear to constitute vertical exclusions. To date, there has been relatively little litigation in this area, although there is growing interest in challenging these anticompetitive practices which serve both to limit the ability of nurses to provide care and the ability of consumers to access that care.

4. Both hospitals and physicians have requested some degree of antitrust immunity. How will this impact your ability to compete and provide high quality care?

Hospital and physician have proposed varying degrees of immunity from antitrust laws for the stated purpose of allowing them to compare prices and to work in concert in the development of arrangements to coordinate health care delivery. We believe that unless nonphysician professionals are also included within such immunity, it will adversely impact on the ability of their ability to provide care by decreasing competition between classes of providers.

We further believe that while arrangements that truly encourage increased efficiency and that enhance access should be allowed, no immunity should be granted for activities that serve to inhibit competition among classes of health care providers. Such activities run directly counter to the goals of health care reform--increasing access, maintaining and improving quality and containing costs. We believe that active steps must be taken to halt such anticompetetive practices in the health care industry.

Further, we believe that health care reform presents both the opportunity and the need to inititate efforts to contain practices which, while they may not violate current antitrust laws, serve to decrease or prevent competition within the health care industry. These include state practice laws which create artificial barriers to practice; state laws which discourage or prohibit nurses from owning health care related businesses; and insurance practices which discriminate against nurses (such as indemnity plans which refuse to pay for services provided by a nurse while paying for the same service when provided by a physician).

PREPARED STATEMENT OF SENATOR HOWARD M. METZENBAUM

Chairman Rockefeller and members of the committee, I am pleased to be here this morning to testify about the need for strong fair competition laws under health care reform. I chaired a hearing similar to this one last March. At that time, my antitrust subcommittee heard testimony which convinced me that American consumers could lose the battle to control the high cost of health care if we weaken our antitrust laws.

Today's hearing comes at an extremely opportune time. The administration's health care task force is putting the final touches on its reform plan. We now know much more about how the new system will work. It is my view, and that of a number of expert witnesses from whom you will hear today, that strong antitrust laws will promote—not hinder—reform under the new health care system.

Doctors, hospitals and other entrenched special interests have launched a furious lobbying effort to weaken the antitrust laws. As you listen to their testimony today, I urge you to remember that if it had not been for vigorous antitrust enforcement, health care reform might not even be possible. When health maintenance organizations—which are the prototype for the new provider networks—first attempted to enter the market doctors and hospitals boycotted them because they saw them as a competitive threat. It took vigorous antitrust enforcement to defeat those collusive boycotts and to pave the way for HMOs to enter the market. U.S. Healthcare, one of the nation's largest HMOs, has warned that "weakening the antitrust laws would hurt competition in health care and cause prices to rise rather than moderate."

Doctors and hospital interest groups have a different view of the antitrust laws. The American Medical Association has made winning antitrust concessions for doctors one of its top lobbying priorities for health care reform. They claim that doctors need "antitrust relief" to bargain with large buyers, like HMOs. However, what they really mean is that they don't want HMOs forcing doctors to moderate their fees, which currently average $170,000 a year.

It is clear to me that the AMA could readily abuse antitrust concessions to undermine the development of new and innovative health networks. According to the Federal Trade Commission, the AMA has a history of opposing new health networks. For example, when cost-cutting HMOs tried to enter the market, the AMA advised its members that it was "unethical" for doctors to contract with them. It also told doctors how to refuse to deal with them. The FTC was forced to sue the AMA to reverse its policy of resisting HMOs.

Therefore, I urge you to examine closely the antitrust concessions that the AMA is now seeking. Their proposal could legalize the kind of collusive price-fixing that the justice department prosecuted successfully in *United States* v. *Alston* in 1990. In that case, a group of dentists conspired to raise their patients' co-payment fees. James Rill, the Bush administration's antitrust chief, called the case "a prime example of *per se* illegal conduct warranting criminal prosecution . . . [that was] wholly unrelated to the formation or operation of a bona fide joint venture." It seems obvious to me that health care reform could be totally undermined by antitrust concessions which could legalize collusive price fixing by doctors.

The American Hospital Association has also made winning antitrust concessions a top lobbying priority. The AHA claims that antitrust enforcement is chilling beneficial hospital mergers and joint ventures. However, when you look at the facts, their claims don't hold up.

Since 1987, there have been over 225 hospital mergers. Of that number, only 22 have required intensive investigation and only 7 have been challenged. Moreover, Federal authorities have not challenged a single joint venture or buying arrangement among hospitals. This is hardly a record of antitrust enforcement run amuck.

The fact is that the antitrust laws have not been used to block hospital deals that would benefit local communities by consolidating unused hospital beds, reducing wasteful competition for high technology equipment, or saving a financially unstable hospital from closing its doors. Rather, the antitrust laws have been used to block mergers that were likely to increase prices and to keep HMOs out of the market.

There have also been claims that rural hospitals should be exempt from the antitrust laws. However, I believe that rural hospitals—like their urban counterparts—actually benefit from appropriate antitrust enforcement. For example, in a March 12th letter to majority leader George Mitchell's staff, the deputy attorney general for the state of Maine warned that:

> competitive problems from hospital agreements are often *more severe* in rural states such as Maine than in large urban areas. This is because the number of hospitals in rural areas is far less . . . and consequently, the parties to a joint agreement in rural states often include most (or, at times, all) of the hospitals in a particular market area.

Rural hospitals should not be exempt from the antitrust laws. Those laws are flexible enough to permit rural hospitals to merge or to enter into joint ventures when those deals benefit local consumers by cutting costs or eliminating unnecessary duplication.

In closing, I would urge you to beware of doctors and hospitals seeking antitrust concessions. The only change that we have to make in the antitrust laws to speed health care reform is the repeal of the McCarran-Ferguson exemption for health insurers. That change would prevent insurance cartels from fixing the price and the terms of health care coverage for consumers.

I hope to able to support the administration's health care reform plan. However, that may not be possible if it weakens the fair competition laws protecting consumers and allows doctors, hospitals or drug makers to dictate the terms of change.

PREPARED STATEMENT OF SENATOR GEORGE J. MITCHELL

Mr. Chairman, I commend you for holding this hearing today to discuss an important issue which affects our efforts to reform the delivery of health care in this country.

The relationship between anti-trust law and efforts to restructure the health care delivery system is an important one, particularly in rural States like Maine.

In my State, hospitals and other health care facilities are attempting to work together in a cooperative fashion to eliminate wasteful duplication of services. In rural States where population density may not allow a competitive health care delivery system to develop, it is important that health care providers have the opportunity and ability to work together to improve the delivery of care while reducing excess capacity and unnecessary duplication of capital.

The development of Community Care Networks, as envisioned by the American Hospital Association and others, makes a great deal of sense in Maine and other states where managed competition may not be viable.

However, many hospitals and other providers feel inhibited to come together because of concern about anti-trust barriers. There has been an ongoing debate about whether an actual barrier exists or whether the perception of a barrier exists. It could be argued that the perception of a barrier is a barrier and will inhibit legitimate cooperative efforts.

I believe that the anti-trust laws are important to protect consumers against unfair collusion and the danger of price-fixing. Consumers must be protected under all circumstances.

Last year the State of Maine passed legislation to facilitate cooperative agreements among Maine hospitals. This legislation is intended to allow agreements among two or more hospitals for the sharing, allocation or referral of patients, personnel, instructional programs, support services and facilities or medical, diagnostic or laboratory facilities.

Maine hospitals are already working to share information and explore ways to use their facilities more cooperatively, in an effort to improve the delivery of care to their patients while reducing unnecessary costs. Rural hospitals in other states are interested in pursuing such cooperative ventures.

The Maine Hospital Cooperation Act includes strong consumer protections. Every proposed collaborative venture must be evaluated by the Maine Department of Human Services and the Maine Attorney General's office. Both must determine that the proposed venture poses no harm to the consumer in order for it to go forward.

It is important to ensure that existing federal antitrust policy does not unnecessarily inhibit health care reform efforts, particularly in rural states. Cooperation among providers may be in the best interest of consumers under some circumstances. It is important that there is enough flexibility to allow such cooperation without undue administrative burden on providers. Where there is no state legislation which may allow such ventures it is important that the federal anti-trust laws are accommodating.

I look forward to the testimony to be presented here today and hope that we can work together to allow flexibility for cooperative ventures while protecting the consumer from harm.

PREPARED STATEMENT OF EUGENE P. PAWLOWSKI

Mr. Chairman, I am Eugene P. Pawlowski, President of Bluefield Regional Medical Center in Bluefield, West Virginia. I also serve on the West Virginia Health Care Planning Commission, which is charged with developing a plan to reform the

West Virginia health care system. On behalf of the American Hospital Association's (AHA) approximately 5,300 institutional members, I am pleased to testify on AHA's view of antitrust in the health care field.

This country is on the verge of comprehensive health reform. As we move toward reform, we are faced with the challenge of finding an acceptable balance between providing greater access to health care services and conserving health care resources. To meet this challenge, we will need to restructure the way health care is delivered in the United States. A necessary part of restructuring the delivery system will be the development of new and innovative relationships between and among providers. The AHA, along with many others, envisions a future health care system founded on community-based provider networks. It is crucial that the antitrust laws accommodate the creation of these networks.

THE NEED FOR CHANGE

The U.S. health care system is unique, both in its strengths and weaknesses. We have a wealth of health care facilities and highly trained personnel, and have long been recognized as a leader in the high quality of health care provided. Our health system encourages clinical innovation and is known for state-of-the-art treatments and technologies.

Despite these strengths, the United States health care system is seriously flawed. Foremost among its problems is inadequate access to health care coverage. There are currently 36 million uninsured individuals in the U.S., 10 million of whom are children. Half of the uninsured live in families with incomes below the poverty threshold. Medicaid, a program originally designed to provide health insurance to the poor, now provides care to only about 40 percent of people living in poverty. As a result of strained federal and state finances, those who do qualify for Medicaid face limitations on the services they receive. Many state Medicaid programs, for example, do not pay for screening and preventive services. Coverage limitations are becoming more common even for the privately insured, as many insurers eliminate benefits in an attempt to control their rising costs.

Another major problem with the current system is the continued rapid growth in health care spending. National health expenditures are rising at an annual rate of over 10 percent and the U.S. currently devotes more than 13 percent of its Gross Domestic Product to health care spending, more than any other nation in the world. However, we still suffer significant deficits in health status. Among the western industrialized democratic nations, the U.S. ranks first in health care spending per capita, but 20th in infant mortality.

Under our current system, the delivery of care remains fragmented. Individuals generally receive care from a changing array of providers and only after they have become ill. Patients are often left to patch together services in a variety of settings from unconnected providers. Our capacity for providing care is excessive in some areas and inadequate in others. For example, some hospitals possess a costly overabundance of high technology equipment, while others have trouble adequately filling their staffing needs.

The highly competitive hospital market of the 1980s exacerbated, rather than alleviated, this country's health care crisis. Market forces have failed to rationally allocate resources in a socially optimal manner and have led to wasteful and costly duplication. Because competitive solutions have failed, hospitals are seeking alternatives that better enable them to meet the needs of their communities.

AHA'S REFORM PLAN

Insufficient access, rising costs, and fragmentation of care have led to patient dissatisfaction with the current health care system. Americans question the value they are receiving for their health care dollars. The United States has the greatest health care available in the world, but our delivery system is in desperate need of repair.

The AHA's vision for health reform calls for universal access to a basic health care benefits package. The set of basic benefits would cover the full range of services from preventive care through long term care. Universal access would be provided by means of a pluralistic system of financing—a combination of private workplace coverage and a new public program consolidating and expanding Medicare and Medicaid. Employers would be first encouraged and ultimately required to provide coverage for their workers and dependents.

AHA's reform plan is founded on the concept of Community Care Networks[sm], providers working together to furnish patients with integrated care organized at the community level. These networks would be consortia of hospitals and other institutional providers, physicians and other health care professionals, insurers, employers, unions and other groups. Networks would be responsible for providing all the cov-

ered health care services for their enrolled population and would coordinate patient care over time and across various provider settings. Patients could turn to their network for everything from preventive care to acute care to long-term care services.

Community care networks would improve the quality of care because they hold the promise for true management of patient care. True managed care requires assessing patient health risks and needs, and planning, organizing, and delivering care so that problems are averted or treated early and all needed services are efficiently provided.

Community care networks, which would receive risk-adjusted capitated payments from purchasers of health care, would encourage providers to conserve health care resources by providing only appropriate and necessary care. Networks would also encourage providers to collaborate with one another to avoid duplication of services.

COLLABORATION CAN BE BENEFICIAL

The AHA is urging the formation of networks because we believe they are the best way for hospitals, other health care providers, businesses, schools, and community organizations to improve the health status of their communities. Greater provider cooperation will lead to controlled costs, improved quality, and expanded access.

Cost Containment

Provider joint efforts can contain high costs by reducing excess capacity and duplicative services. A number of studies[1] completed since 1987 address the relationship between market concentration, which is a function of the number of competitors in a market and their respective market shares, and increased costs and/or prices. Market concentration typically increases when competitors merge or engage in other cooperative activities.

The government's antitrust policy assumes that greater market concentration is likely to lead to higher prices. Many of the studies referenced above fail to support this assumption. Instead, the studies provide direct or indirect support for the proposition that collaborative efforts can lead to greater efficiency. Some of these studies demonstrate a statistically significant correlation between higher market concentration and lower prices and/or costs. Other studies merely suggest that there is no positive correlation between higher market concentration and higher costs and/or prices. Overall, the studies cast doubt on the presumption that in concentrated hospital markets, increased market concentration, by itself, will lead to higher prices and/or costs to purchasers of health care services.

For example, a study published in June 1992 by the Inspector General of the Department of Health and Human Services (HHS) suggests that both operating and capital costs are lower in markets in which a merger occurred. The study also concluded that for merged hospitals, medical and other service costs were reduced 10.4 percent, while the same costs in the non-merged control group increased 29.7 percent.

In *In re: Adventist Health Systems/West,* a recent case in which the Federal Trade Commission (FTC) challenged a hospital merger in Ukiah, California, the Administrative Law Judge (ALJ) affirmed the notion that cooperative efforts can lead to greater efficiency. As the ALJ noted "[t]he facts belie" the claim that "competition among health care providers will give consumers the same benefits as competition in other industries . . . ."[2] The ALJ concluded that "[c]ompetition did exist between [the] hospitals . . . but it appears to have *increased* the costs of hospital care in the Ukiah area through duplication of services. . . ."[3]

Quality

Provider collaboration can also improve the quality of health care. Provider cooperation, by consolidating the market, tends to increase the volume of procedures performed by any given provider. Studies have concluded that, at least for certain services, increased volume leads to reduced risks, greater proficiency, and higher levels of quality. The ALJ in *In re: Adventist Health Systems/West* implicitly supported this assertion when he noted that, "the creation of a hospital which is larger and more efficient . . . will provide better medical care . . . ."[4]

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[1] These studies are specifically identified and discussed in Appendix D of the AHA's report, *Hospital Collaboration: The Need for an Appropriate Antitrust Policy.*

[2] *In re: Adventist Health Systems/West,* Docket No. 9234 at 44 (Dec. 9, 1992).

[3] *Id.* (emphasis added).

[4] *Id.*

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Provider cooperation can also increase access to health care services. A recent *Hospitals* magazine survey indicated that the two areas in which hospitals most frequently collaborate are community outreach and the development of a continuum of care in the community.[5] Indeed, many cooperative activities have been motivated, at least in part, by a desire to maintain important but unprofitable services, including programs addressed to underserved population groups, and to spread the burden of those programs. Strict reliance on traditional price competition mechanisms, however, does not reward efforts to be sensitive to these social priorities. Federal enforcement standards do not recognize this dimension of the problem and, in at least one hospital merger case, the government expressly contested the hospitals' assertion that an enhanced ability to subsidize indigent care was a legitimate benefit of the merger.[6]

Whether AHA's concept of community care networks will be incorporated into this country's health reform plan is unclear. It is clear, however, that reform will take place and that it will entail new and novel provider relationships. Because current antitrust laws and enforcement pose an obstacle to the formation of certain provider relationships, a more flexible national antitrust policy will be needed.

ANTITRUST IS AN OBSTACLE TO COLLABORATION

The antitrust laws and their enforcement pose a range of problems for hospitals and other providers, particularly those seeking to form and participate in networks. Some collaborative activities that would be beneficial to patients and purchasers of health care are clearly prohibited under current law. Many other arrangements fall into a gray area, and it is unclear whether the antitrust laws would prevent their implementation. Finally, misunderstanding or misperception of the antitrust laws may deter some providers from engaging in joint activity that is in fact permissible.

Under current law, hospitals cannot agree to allocate services among themselves based on location or the type of services provided, even if the allocation is recognized as beneficial by consumers—including the business community, one of the largest purchasers of health care. For example, two hospitals cannot agree that one will purchase an MRI and the other will purchase a lithotripter, instead of each purchasing both pieces of equipment, despite the fact that the agreement could avoid unnecessary duplication of equipment and services. Such an agreement would be considered "market division," a *per se* violation of the antitrust laws.

This dilemma is illustrated by a recent inquiry from the president of the Wichita, Kansas Chamber of Commerce to the FTC. The Chamber of Commerce, expressing concern about the costs of unnecessary duplication of health care services in the Wichita area, asked whether the antitrust laws would prohibit the Wichita hospitals from meeting to collectively allocate services, equipment, or facilities among themselves. The Chamber of Commerce also inquired as to whether the involvement of organizations with wide community support in such allocation decisions could reduce antitrust risk.

The FTC responded negatively to the Chamber's inquiry, emphasizing that:

> An agreement among competitors to divide or allocate markets—whether on a geographic, customer, or product line basis—is per se illegal under the Sherman Act. Such agreements have been held to be so inherently anticompetitive they have been condemned without inquiry into whether or to what extent competition is actually affected by them. *Addyston Pine & Steel Co.* v. *United States,* 175 U.S. 211 (1899). This rule of per se illegality governs private agreements among hospitals or other health care providers to divide markets.[7]

The FTC then went on to state that the involvement of community leaders could not alleviate the agency's concerns:

> You should however be aware that the mere fact that the community business leaders support or participate in an agreement among health care providers to allocate resources or services will not immunize or protect the

[5] *Hospitals,* Feb. 20, 1993 at 56 (survey conducted by Hamilton/KSA).

[6] Deposition of Robin Allen, at 466–73 (Nov. 23, 1988), *United States* v. *Carilion Health Sys.,* 707 F. Supp. 840 (W.D. Va.) (No. Civ. A. 88–0249–R), *aff'd,* 892 F.2d 1042 (4th Cir. 1989).

[7] Letter from Mark J. Horoschak, Assistant Director, Federal Trade Commission, to F. Tim Witsman, President, Wichita Area Chamber of Commerce (May 22, 1991) (on file with the Federal Trade Commission) (hereinafter "Horoschak Letter").

> providers or other participants from liability for an otherwise illegal agreement in restraint of competition under the antitrust laws.[8]

Most joint arrangements, including mergers, acquisitions, and joint ventures, are evaluated under the "rule of reason" standard, rather than the per se standard applicable to allocation agreements. The threshold question under the rule of reason is whether the arrangement creates or enhances "market power." Market power, which is generally measured by the rough proxies of market share and market concentration, exists when a party can profitably increase price above, or decrease output below, competitive levels.

Under the 1992 Merger Guidelines issued jointly by the FTC and Department of Justice (DOJ), virtually all communities with six or fewer hospitals are "highly concentrated" markets. Accordingly, in more than 80 percent of the United States communities that have more than one hospital, any reduction in the number of hospitals, through merger or acquisition, is presumptively illegal. Sound antitrust policy regarding hospital markets should highlight the potential for collaborative efficiencies and move away from a rigid focus on increases in market concentration.

Enforcement agency analysis of joint ventures also focuses on market concentration. Antitrust risks may be substantial, at least in communities with few hospitals, if two or more hospitals reduce existing duplication of services or equipment by joint venturing services in an area in which they currently compete.[9] Regarding joint ventures, the DOJ has stated:

> Notwithstanding the efficiency-enhancing potential of joint ventures generally, it is possible that a particular health-care joint venture could significantly increase health-care costs by significantly lessening competitive forces that are increasingly being relied upon to keep those costs down.[10]

In addition, the FTC has stated that the parties to joint ventures risk antitrust scrutiny by agreeing to a common price to be charged for the joint venture product:

> [A]n agreement among the venturers to impose the same charges for use of the equipment would not appear to be reasonably necessary to accomplish the purpose of the venture. Such an agreement, standing alone, would be unlawful, and depending on the circumstances could invalidate the joint venture under the rule of reason.[11]

Given the lack of precision in this advice, it is understandable that hospitals are often unsure of their joint venture alternatives. In fact, the DOJ recently acknowledged that adding certainty to antitrust enforcement is important, at least with respect—to joint ventures involving high technology equipment:

> . . . pending legislation to reduce antitrust uncertainty and risk in the joint venture area generally may be of benefit to hospitals that wish jointly to purchase high technology equipment or services.[12]

Although this limited recognition of the problem is somewhat encouraging, the need to reduce uncertainty is no less important for other forms of beneficial hospital collaboration than it is with respect to joint acquisitions of high technology equipment.

Even where the antitrust laws may not pose a clear threat, other factors create a "chilling effect" on hospitals' efforts to work together. Inadequate guidance from the federal government (particularly given the current health care environment), the threat of lawsuits by competitors, the potential for treble damages and/or criminal prosecution, and the time and expense associated with challenges by enforcement agencies and/or private parties combine to inhibit hospital initiatives. In spite of the collaboration currently occurring within the hospital field, a *Hospitals* magazine poll indicated that more than 44 percent of surveyed hospital CEOs agreed that antitrust concerns have slowed down or inhibited further collaborative efforts.[13]

The federal enforcement agencies have stated publicly that hospitals should not be overly concerned about the lack of specific guidance relating to hospital markets because the government has challenged very few hospital transactions. The problem

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[8] *Id.*

[9] Where a joint venture is necessary to introduce new or enhanced products to a community, antitrust risks may be reduced.

[10] Letter from W. Lee Rawls, Assistant Attorney General, U.S. Department of Justice, to Senator Nancy Kassebaum, United States Senate (March 10, 1992) (on file with the United States Department of Justice Antitrust Division) (hereinafter "Rawls Letter").

[11] Horoschak Letter, *supra* note 7.

[12] Rawls Letter, *supra* note 10.

[13] *Hospitals,* April 20, 1992 at 60.

with this assertion is that neither the 1992 Guidelines nor any other policy pronouncement by the enforcement agencies enables hospitals to clearly distinguish the circumstances in which—their specific collaborative arrangement would, in fact, be challenged from those in which it would not. Given that a large percentage of collaborative arrangements are presumptively illegal under the government's existing market concentration standard, the absence of challenges serves to create, rather than diminish, uncertainty. The uncertainty makes it difficult for hospitals to readily obtain clear legal advice on the validity of proposed transactions.

Nor is this uncertainty diminished by either of the two principal avenues for obtaining prior government review of joint arrangements. The Hart-Scott-Rodino Antitrust Improvements Act (HRSA), 15 U.S.C. §18a, establishes mandatory notification and review requirements for certain specified transactions, but does not preclude the agencies or private parties from later challenging the transaction. In addition, the time and expense of HRSA review is often substantial, particularly if the enforcement agencies request a large volume of documents and information, as they are authorized to do.

Parties to proposed joint arrangements not subject to mandatory HRSA review may seek advisory opinions from the federal enforcement agencies. For a number of reasons, however, the utility of these voluntary review processes is extremely limited. Perhaps most important, the process is simply too slow to be useful in many situations and provides little real help for hospitals seeking prompt and efficacious guidance regarding the likelihood of challenge to a proposed merger or joint venture.[14]

Where the problem is one of misperception alone, the AHA is attempting to address hospitals' antitrust concerns by educating its members. For example, the AHA has published a *Q & A Report* addressing the antitrust implications of collaborative activities. The AHA's educational efforts, however, cannot resolve the uncertainty inherent in the antitrust laws or change the laws' preference for competition, even where competition results in unnecessary duplication of services and equipment.

ANTITRUST POSES A SPECIAL PROBLEM FOR HEALTH CARE PROVIDERS

The antitrust statutes reflect "a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services. . . . The assumption that competition is the best method for allocating resources in a free market recognizes that all elements of a bargain—quality, service, safety and durability—and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers."[15] For hospitals, however, competitively-structured markets may not produce an optimal allocation of resources.

In hospital markets, most individual consumers (including those who are beneficiaries of public programs) are insulated from market prices by third-party insurance. Moreover, individual consumers frequently lack the ability to choose particular hospital services, a task that is performed by, or at least shared with, physicians. Consequently, the person who pays for a hospital service (the insurer) neither demands it nor uses it.[16] The patient and the physician (who together create the demand) pay little or nothing for the service; therefore, the demand for hospital services is generally higher than it would be if patients paid the full cost for services.

[H]ealth care markets differ in many respects from the textbook model of the competitive market. In particular, the relative lack of information available to patients, and the presence of health care insurance which blunts the impact of price on patients' purchasing decisions, have been cited as factors that may impede normal competitive processes in health care markets.

James C. Egan, Jr., Acting Director for Litigation, Federal Trade Commission Bureau of Competition, testimony at hearings on "The Structure of the Hospital Industry in the 21st Century" before the Subcommittee on Investment, Jobs and Prices of the Joint Economic Committee, 102d Cong., 2nd Sess. (June 24, 1992) (transcript available from the Joint Economic Committee).

Because insurance covers most of the cost of hospital care, patients (and their physicians) traditionally have had little incentive to select hospital services on the basis of price. If all hospitals effectively cost the same to individual patients (or the differences in coinsurance costs are relatively small), the patient and/or physician

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[14] In at least one case, the government response time exceeded three and one-half years. In any event, the response ultimately obtained may not be definitive. The DOJ recently began a pilot program intended to expedite the business review process. While we appreciate this acknowledgement of the problem, it is too soon to tell whether the pilot program will be successful.

[15] *National Soc'y of Professional Eng'rs* v. *United States*, 435 U.S. 679, 695 (1978).

[16] The FTC has acknowledged this fact, at least in theory:

will select the one that offers the greatest combination of services, amenities, convenience, and perceived quality. This, of course, is an incentive for all hospitals to maximize their investment in those areas and thereby drive up their costs.

Hospital behavior often differs from the competitive paradigm in another respect. The competitive model presumes that firms seek to maximize their profits and, concomitantly, that firms with market power (i.e., few competitors) will always use that power to increase prices. Hospitals with market power, however, may be constrained in their ability or willingness to exercise that power. These constraints arise from factors that are in many ways peculiar to the hospital field.

In many cases, a hospital's ability to exercise market power is limited by the fact that its pricing decisions affect a relatively small portion of its business. Medicare, Medicaid, CHAMPUS, and other publicly-sponsored payment programs, for example, set their own payments by regulation. The average hospital receives more than 50% of its gross revenues from regulated sources and furnishes a significant portion of uncompensated care. Increases in hospital charges generate no additional revenue from these patients. The ALJ in *In re Adventist Health Systems/West* recognized this fact in his decision:

> [T]he acquisition can have no effect with respect to Medicare, Medi-Cal and no-pay patients, for Ukiah Valley cannot charge prices which exceed the amounts allowed by Medicare and Medi-Cal and receives nothing from no-pay patients.[17]

Price increases also may be ineffective for private payers that have long-term contracts.

Hospitals, while necessarily cognizant of economic considerations, are not mere businesses, any more than educational, religious, public, and other community-based institutions are just businesses. Although the governing boards of all corporations have a fiduciary responsibility to act in the best interest of those corporations, the mission of a community hospital typically is defined in terms of community service and community benefit (including, e.g., the provision of charity care). Most hospitals are governed by local, community-based boards that are attuned to the hospital's mission and recognize that attainment of community objectives may involve actions that are inconsistent with maximizing the hospital's surplus. It therefore cannot be assumed that hospitals will operate identically to traditional commercial enterprises. It is also significant that, in most communities, hospital board membership is heavily representative of local businesses that are major purchasers of health care. These representatives have a specific interest in ensuring that hospital rates are not excessive.

The antitrust laws presume that market forces will eliminate excess capacity from the system. With respect to hospitals, however, the ability of market forces to rationally allocate resources in a socially optimal manner is questionable. Market solutions will take longer to achieve reduction of excess capacity than will collaborative strategies. The faster excess capacity is reduced, the faster the costs associated with excess capacity can be eliminated.

Antitrust policy must also be sensitive to noneconomic priorities in health care. Quality of care may be adversely affected, as economically depressed hospitals can remain in business for some time after quality is compromised. In addition, market forces may not ensure that the right hospitals remain open; hospital closures in underserved areas would exacerbate already serious problems with access to care.

The foregoing factors—the distancing of consumers from the demand for services, the existence of non-price constraints on hospital behavior, and the need to allocate resources in a manner that is socially, not just economically, optimal—provide support for the hospital field's pursuit of collaborative strategies as the most effective way to eliminate excess capacity and reduce costs. Collaborative arrangements provide opportunities to operate services or facilities on a more efficient scale and to convert scarce resources to alternative uses.

THE NEED FOR CHANGE IS WIDELY RECOGNIZED

The AHA is not alone in recognizing the need for flexibility under the antitrust laws as we move toward reform of the health care delivery system. In December 1991, the Advisory Council on Social Security recommended that the Attorney General develop legislation that would permit more hospital mergers.[18] The Council also recommended that the Attorney General and the Secretary of HHS jointly develop

[17] *In re Adventist Health Systems/West* at 43.

[18] 1991 Advisory Council on Social Security, pp. 126 (Dec. 1991).

legislation to permit two hospitals in the same community to joint venture in order to provide hospital and health-related services.[19]

Last year, the Bush Administration's health care reform program recognized the need to ensure that the antitrust laws do not impede health care reform. The plan urged that "concerns of antitrust liability do not chill the evolution of a more organized and efficient delivery system."[20]

This year, reports indicate that President Clinton's Task Force on National Health Care Reform is considering the need to modify the antitrust laws. As reported recently in the *N.Y. Times* "[c]onfidential work papers from the President's Task Force on National Health Care Reform, headed by Hillary Rodham Clinton, suggest that antitrust laws may need to be modified 'to permit collaborative arrangements' or to change the balance of power between buyers and sellers of health care."[21]

Federal lawmakers have recognized the need for antitrust flexibility as well. Over the past two years, several Members of Congress have introduced legislation that would limit and/or remove the antitrust barriers to certain forms of hospital collaboration. These legislators include Senators Bill Cohen (R–ME) and Orrin Hatch (R–UT), and Representatives Jim Slattery (D–KS), Peter Hoagland (D–NE), Bob Michel (R–IL), Connie Morella (R–MD), and Larry LaRocco (D–ID). All the proposals, in varying ways, seek to address the growing interest in and need to facilitate cooperation among and between hospitals.

Many options are available to encourage collaboration. One approach that would help lay the groundwork for network formation would be to establish a voluntary waiver, or preclearance, program for hospitals engaged in certain collaborative arrangements to provide health care. Another approach would be development of enforcement guidelines specific to health care collaborative activities. Such short-term proposals, however, may be unnecessary if comprehensive health reform appropriately modifies antitrust policy.

Note that a waiver approach could be based in part on state statutes that seek, to varying degrees, to protect hospitals' cooperative arrangements from state antitrust laws and to provide "state action immunity" from the federal antitrust laws.[22] Maine, Minnesota, Ohio, Washington, and Wisconsin have already enacted such statutes, and similar bills have been introduced in Colorado, Illinois, Indiana, Kansas, Massachusetts, North Dakota and West Virginia. Hospitals in at least ten other states have expressed interest in this issue. This growing movement for antitrust reform at the state level confirms that providers and state lawmakers consider the antitrust laws to be significant barriers to cooperative activity that would benefit consumers and purchasers of health care.

CONCLUSION

AHA strongly supports reform of the health care delivery system. In view of the Clinton Administration's—indeed, the entire country's—emphasis on health reform as a top priority, AHA believes that it is necessary to examine antitrust policy within the reform context and eliminate inappropriate barriers to collaboration. While AHA cannot offer a specific legislative solution without knowing the details of the health care reform package to be offered to Congress, it seems that the following issues will need to be considered.

To the extent that networks of hospitals, physicians and other providers are an integral part of reform, the appropriate goal is to encourage competition between the networks. Policy-makers will need to consider that some areas, for example, rural communities, may be unable to support more than one network due to geographic location and/or resources. In either case, policies that inhibit the formation of networks, or collaboration between providers within a network, are inconsistent with the goals of reform. Additionally, formation of efficient networks will necessarily exclude some providers, raising antitrust issues that will need to be addressed.

AHA believes that certain principles undoubtedly must be recognized as part of health care reform.

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[19] *Id.* at 126–127.

[20] The President's Comprehensive Health Reform Program, p. 55 (Feb. 6, 1992).

[21] *N.Y. Times*, March 10, 1993 at A1, A8.

[22] The state action doctrine exempts from antitrust scrutiny conduct that is undertaken pursuant to an affirmative state policy reflecting an intent to replace competition with regulation, provided that the conduct is actively supervised by the state.

- Protecting consumer interests is an underlying objective of both the antitrust laws and health care reform. Given this mutual goal, health and antitrust policies should be compatible.
- The benefits of improved quality and access as a result of provider collaboration must be emphasized.
- Collaboration can result in real cost containment by eliminating excess capacity and unnecessary duplication of equipment and services.
- The special needs of local communities should be paramount. Collaborative efforts to meet local community health needs should be encouraged.
- Greater emphasis should be placed on the potential for efficiencies in hospital markets, particularly given the existing over-capacity and duplication of equipment and services.
- Because hospital markets are inherently concentrated, particularly in less populated areas, less emphasis should be placed upon market concentration.

A clear tension exists between federal antitrust law and collaborative solutions to national health policy concerns. As the country contemplates comprehensive health reform, we need to ensure that innovative ideas for delivering better and more efficient care are not thwarted by the antitrust laws.

RESPONSES OF EUGENE PAWLOSKI TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question No. 1. What proportion of your member institutions are concerned about the threat of antitrust litigation?

Answer. The inability to predict whether particular arrangements will violate the antitrust laws, coupled with the potential time and expense of antitrust investigations and litigation, is a significant barrier to hospital collaborative efforts. A 1992 survey by Hospitals magazine found that 44 percent of the hospital CEOs who responded agreed that antitrust concerns have slowed down or inhibited hospitals' collaborative efforts. Julie Johnsson, *Collaboration Grows Despite Antitrust Rules,* Hospitals, April 20, 1992, at 60. Although the same study noted that approximately 75 percent of the respondents were currently collaborating or planning to share services, the high level of perceived antitrust concern suggests that hospitals may be limiting their collaborative arrangements to those that raise few antitrust risks. The growing movement for antitrust reform at the state level confirms that providers and state law makers consider the antitrust laws to be significant barriers to cooperative activity that would benefit consumers and purchasers of health care.

Question No. 2. What proportion of your membership would benefit from mergers and joint ventures.

Answer. We are not aware of any surveys or studies that directly address this question. It is reasonable to presume, however, that many of the hospital CEOs who indicated in the above-described survey that the antitrust laws "chilled" cooperative activities, would engage in such activities if their antitrust concerns were alleviated.

Question No. 2A. Of those member hospitals who would benefit from joint venture and merger activities, what proportion of hospitals refused to engage in these activities for fear of antitrust litigation?

Answer. See answer to Question No. 1.

Question No. 3. Will the DoJ's new guidelines for mergers and joint ventures minimize the perceived risk of your member institutions to antitrust litigation?

Answer. For a number of reasons, the 1992 Horizontal Merger Guidelines will not alleviate hospitals concerns regarding antitrust enforcement and litigation. First, the guidelines are not specific to health care, so hospitals are treated in the same manner as grocery stores or steel companies and health care considerations (for example, avoiding duplication of services and equipment) are not addressed. Second, because virtually all communities with six or fewer hospitals are "highly concentrated," in more than 80 percent of the United States communities that have more than one hospital, any reduction in the number of hospitals, through merger or acquisition, is presumptively illegal under the Guidelines. Third, because a large percentage of collaborative arrangements are presumptively illegal under the government's existing market concentration standard, the absence of challenges serves to create, rather than diminish, uncertainty. Unfortunately, neither the Guidelines nor any other policy pronouncement by the enforcement agencies enable hospitals to clearly distinguish the circumstances in which their specific collaborative arrangement would, in fact, be challenged from those in which it would not.

Question No. 4. In your proposal to develop community care networks, you advocate antitrust immunity for the CCNs. If the CCNs are developed by state law, wouldn't 'state action' immunity be sufficient to protect CCNs from antitrust litigation?

Answer. AHA's health reform proposal highlights the need for antitrust reform that allows for greater provider collaboration. Antitrust immunity for networks is one possible option.

State legislation seeking to provide state action immunity may or may not be sufficient to protect networks from antitrust litigation. Whether private parties are shielded from federal antitrust law by state regulation is determined by a two-pronged test. First, there must be a clearly articulated and affirmatively expressed state policy to displace competition. Second, the state must actively supervise its policy allowing any private anticompetitive conduct. *California Retail Liquor Dealers' Ass'n.* v. *Midcal Aluminum, Inc.,* 445 U.S. 97 (1980).

The case law regarding the state action doctrine is not well-developed and it is therefore difficult to predict with any certainty whether a particular statutory scheme will confer immunity. Providers may be hesitant to participate in networks until the state regulatory scheme has been found sufficient by the courts. In addition, there is no guarantee that legislation protecting network participants under the state action doctrine will be enacted in every state or, especially important to providers located near state borders, that the state legislation will be consistent.

Question No. 5. Can you please comment on some of the points made by the FTC? What would an "expedited" review mean to you?

Answer. (a) The FTC made two points on which AHA was asked to comment. First, the FTC quoted from a 1989 AHA publication on mergers, "The general framework for analyzing the antitrust ramifications of hospital mergers is well established." *Hospital Mergers: An Executive's Guide through the Antitrust Thicket,* September 1989, p. 20. (Note: AHA has since published a more recent paper, *Hospital Collaboration: The Need for an Appropriate Antitrust Policy,* 1992.) As indicated in the answer to question No. 3 above, the framework for analyzing mergers is indeed general and is not specific to health care. In addition, the guidelines relate only to mergers and do not discuss the realm of joint activity which may enable hospitals and other providers to furnish better and more efficient care. These and other issues related to the merger guidelines are discussed in the 1992 publication cited above (copy attached).

Second, the FTC indicated that hospitals can seek advice from an enforcement agency which signals whether the agency would challenge activity, and that hospitals can pick up the phone and call the agencies for informal advice. Although both the FTC and the Department of Justice have processes for seeking formal advice, various problems exist. The processes currently available are generally expensive and response time is long (up to 3½ years, in one case). Whether the agency responds to the request for advice is at the discretion of the agency, and answers, if received, can be inconclusive. While a response may indicate a particular agency's enforcement intention at the time of the response, the response does not prevent private parties from bringing suit (or the agency from later bringing suit), thereby failing to provide the certainty hospitals seek. With regard to the agencies offer of advice over the telephone, such advice would not provide certainty unless it is confirmed in writing. Informal, oral advice also fails to prevent, or even deter, private party actions.

(b) "Expedited" review usually refers to a reduction in the amount of time it takes to process a request for a business review letter or an advisory opinion. Expediting these processes would be a positive development; however, other problems, including those discussed above, would still remain. An effective review process needs to provide definitive responses and a clear articulation of reasons why activity might be challenged. In addition, currently, responses are not binding on either state agencies or private parties.

Question No. 6. In your testimony, you said that a for-profit hospital in Bluefield threatened to sue you because of your conversations with another hospital in Bluefield. First, what were you hoping to accomplish with the other hospital? Were you planning a joint venture, a merger? What did the other hospital fear?

This is a case of one hospital threatening to sue another hospital, is that typical? Do threat of lawsuits generally come from other hospitals?

Based on what you heard today, do you think you might reopen your talks with the other hospital in Bluefield? What about seeking an opinion from the Department of Justice or the FTC?

Anwer. On March 22, 1993, Bluefield Regional Medical Center, two other local hospitals, and the Mercer County Health Department conducted a public meeting to review the Rosenberg & Associates' report, *Health Care Reform: A West Virginia Community Care Networks Model,* and listen to a presentation by Mr. Rosenberg. Prior to this meeting, Bluefield Regional Medical Center and one of the other hospitals had met several times to discuss the possibility of implementing the Rosenberg model so that they could improve access, enhance quality and reduce costs. Im-

mediately after the meeting, however, an officer of the third hospital informed the Bluefield partner in these negotiations that any further discussion with Bluefield Regional Medical Center would result in an antitrust lawsuit against both hospitals and their presidents. Subsequently, legal counsel for both hospitals recommended that the hospitals cease any discussions regarding implementation of the Rosenberg study.

Bluefield Regional Medical Center does not know why the third hospital wanted to prevent the cooperative activities from being considered. When two or more hospitals merge or otherwise cooperate, however, it is not uncommon that a competitor hospital feels threatened. These hospitals may file lawsuits against the collaborating entities, but such litigation is not frequent. It is more common for the excluded provider to complain to state or federal antitrust enforcement agencies. As we move toward the provision of care by community-based networks of providers, the threat of litigation by excluded providers will intensify.

What I heard during the May 7, 1993 hearing reinforced my belief that the complicated processes involved and the potential cost of defending antitrust challenges make it too risky to pursue further discussions regarding cooperative activities. In addition, during the hearing I became convinced that the federal enforcement agencies have a strong bias against cooperative ventures. In the absence of definitive guidelines, Bluefield Regional Medical Center feels it cannot safely renew its discussions regarding potential cooperative activities.

Response of Eugene Pawlowski to a Question Submitted by Senator Durenberger

Question. Recognizing that competition in health care services may not always be in the best public interest (for example, competition in some areas can result in duplication of services or excess capacity) would it be enough to clarify in statute that all proposed arrangements would be judged under the "rule of reason?" In other words, all health service arrangement proposals would be judged on a case-by-case basis rather than excluding arrangements that may be judged inherently anticompetitive in a text book market.

Answer. Currently, most proposed cooperative arrangements are judged under a rule of reason analysis; market allocation arrangements, however, are considered *per se* violations of the law. Hospitals and other providers would benefit if arrangements to allocate health resources were no longer a *per se* violation of the antitrust laws. Even a rule of reason analysis, however, involves significant problems.

Rule of reason analysis requires the fact finder to weigh all the factors surrounding the alleged restraint, including the nature the conduct, its purpose, and its actual and potential effect a consumer choice, price, or output. Because the rule of reason is imprecise, it is often difficult for providers to predict whether conduct will pass muster under it. *See, e.g., Assam Drug Co.* v. *Miller Brewing Co.,* 798 F.2d 311, 315 (8th Cir. 1986) ("the rule of reason is a vacuous standard and provides little concrete direction"); *Valley Liquors. Inc.* v. *Renfield Importers, Ltd.,* 678 F.2d 742, 745 (7th Cir. 1982) ("this test of illegality is easier to state than to apply"). Hospitals need more specific ad detailed guidance that will enable them to determine, with a reasonable degree of certainty, whether their activities comply with the antitrust laws.

Hospital Collaboration: The Need for an Appropriate Antitrust Policy [1]

EXECUTIVE SUMMARY

Insufficient access, fragmentation of health care, and rising costs have lead to widespread dissatisfaction with the current health care system and have caused Americans to seriously question the value they are receiving for their health care dollars. Until the early 1970s, the federal government subsidized hospital construction and, through Medicare cost reimbursement, encouraged widespread expansion of services and amenities. Despite subsequent health planning attempts, the basic build-and-spend incentives remained in place until the mid-1980s, when regulatory and market conditions changed dramatically. The advent of Medicare prospective payment in 1983, combined with the continued growth of managed care in the private sector and rapid technological change, produced a surfeit of empty hospital beds. As a result American hospitals are supporting a costly and underutilized infrastructure.

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[1]This paper was prepared by the American Hospital Association's Office of the General Counsel. We would like to thank William G. Kopit. Robert W. McCann, and Karen Ann P. Lloyd of Epstein Becker & Green, P.C. for their assistance.

Uncertainty is Impeding Hospital Collaboration

The hospital field is now engaged in a search for strategies that will reduce costs and improve the rationality of resource allocation. The American Hospital Association (AHA) has urged hospitals to collaborate with each other and with other health care providers, as well as with businesses, schools, and community organizations as a means of improving access and quality and reducing the precipitous rise of health care costs. Many such collaborative arrangements, however, have run into significant barriers—both real and perceived—under the federal antitrust laws.

Misunderstanding or misperception of the antitrust laws may deter some providers from engaging in joint activity that is in fact permissible. Some collaborative activities that would be beneficial to patients and purchasers of health care are clearly prohibited. Many other arrangements fall into a gray area, and it is unclear whether the antitrust laws would prevent their implementation.

The AHA is attempting to address hospitals' misperceptions of the antitrust laws by better educating its members. For example, earlier this year the AHA published the first in a series of *Q & A Reports* addressing the antitrust implications of collaborative activities. The AHA'S educational efforts, however, cannot resolve the uncertainties inherent in the antitrust laws or change the laws' preference for competition, even where such competition results in a wasteful use of resources. This paper examines these issues and is intended to focus attention on the conflict between current antitrust enforcement policy and collaborative solutions to national health policy concerns.

The Nature of the Antitrust Laws

Potential antitrust violations are analyzed under one of two standards, depending on the type of conduct or arrangement involved. "Per se" violations of the antitrust laws involve categories of joint conduct that are believed to be so unlikely to produce redeeming consumer benefits that the conduct is conclusively presumed to be unreasonable, without examination of its actual or potential market effects. This category of violation includes agreements by hospitals to allocate services or customers.

Most joint arrangements, including mergers, acquisitions, and joint ventures, are evaluated under the "rule of reason" standard, and not the per se standard. Rule of reason analysis obligates the fact-finder to weigh all of the factors surrounding the alleged restraint, but the threshold question is whether the arrangement creates or enhances market power.

Current Federal Guidance is Insufficient

The rule of reason standard is difficult to apply. Even where the federal enforcement agencies have attempted to provide guidance, such as the Merger Guidelines, the guidance does not explain enforcement decisions. For example, the enforcement agencies have made apparently inconsistent decisions regarding hospital mergers. These inconsistencies cannot be explained by the Guidelines, which focus primarily on market concentration.

The enforcement agencies insist that they look beyond market concentration to the potential efficiencies of a joint arrangement in deciding whether to proceed with an investigation or challenge. The agencies, however, have not explained with any precision what the nature or extent of the efficiencies must be, or what proof must be offered by hospitals to show that efficiencies do or will exist.

Hospitals' uncertainty regarding the application of the antitrust laws to their collaborative activities is not diminished by the enforcement agencies' mandatory and voluntary review processes. These processes are time-consuming, potentially costly, and may not result in a definitive response.

If collaboration is indeed an important strategy for addressing the problem of overcapacity and rationalizing resource allocation, hospitals must be able to distinguish "good" from "bad" collaboration. At present, the basis for such an understanding is lacking.

There is a Conflict Between the Antitrust Laws and Cost Containment

In addition to providing explicit guidance to hospitals, appropriate antitrust enforcement policy must recognize the unique characteristics of hospital markets. The antitrust laws, which are intended to promote consumer welfare, are based on the presumption that competition is the best method of allocating resources. As noted above, market concentration is the principal measure used to determine whether competition will be unduly harmed by joint activities.

Hospital service markets, however, traditionally have deviated from this competitive paradigm in a number of important respects. First, most individual hospital consumers are insulated from market prices by third party insurance and lack the information, on their own, to choose hospital services. Because the price to the

consumer is artificially low, demand for hospital services is greater than it would be if consumers paid the true economic cost of the services. Second, hospitals with market power may be constrained as to their ability to exercise market power. For example, Medicare, Medicaid, CHAMPUS, and other publicly sponsored programs set their own payments by regulation. A hospital's willingness to exercise market power may also be limited by its mission, which is frequently inconsistent with maximizing surplus.

A number of studies completed since 1987 fail to support the government's assumption that greater market concentration is likely to lead to higher prices. Instead, they provide direct or indirect support for the proposition that collaborative efforts can lead to greater efficiency. Indeed, recent evidence suggests that collaboration among hospitals can reduce costs. Sound antitrust policy regarding hospital markets should highlight the potential for collaborative efficiencies and move away from a rigid focus on increases in market concentration.

The antitrust laws presume that market forces will eliminate excess capacity from the system. With respect to hospitals, however, the ability of market forces to rationally allocate resources in a socially optimal manner is questionable. Market solutions will take longer to achieve reduction of excess capacity than will collaborative strategies. The faster excess capacity is reduced, the faster the costs associated with excess capacity can be eliminated.

Antitrust policy must also be sensitive to noneconomic priorities in health care. Quality of care may be adversely affected, as economically depressed hospitals can remain in business for some time after quality is compromised. In addition, market forces may not ensure that the right hospitals remain open; hospital closures in underserved areas would exacerbate already serious problems with access to care.

The Need for An Appropriate Hospital Market Policy is Clear

As a result of the extensive and costly overcapacity that currently exists, the hospital field will be forced to downsize. Antitrust policy should be consistent with each community's need to rationally address its unique health care concerns and reduce costly overcapacity and unnecessary duplication.

PREPARED STATEMENT OF PHILLIP A. PROGER

Mr. Chairman and Members of the Subcommittee: My name is Phillip A. Proger. I am a practicing lawyer here in Washington, D.C. specializing in antitrust law. I spend a considerable part of my time representing health care and insurance clients with respect to the application of antitrust law to the health care industry.

I appreciate the opportunity to address this Subcommittee regarding antitrust issues in the health care industry. Today I understand that you are interested in whether our federal antitrust laws are a barrier to the development and operation of integrated health care networks or to lowering the costs of health care. As I will discuss in my prepared statement I believe that the answer to that question is that the antitrust laws are not barriers. I am also-available to respond to your questions.

PREFACE

I would like to preface my statement with a few comments on the current state of antitrust enforcement in the health care industry. I understand that members of the Subcommittee are concerned about whether competition works in the health care industry, particularly in rural areas and whether antitrust enforcement or the mere perception of antitrust enforcement has deterred collaborative efforts by hospitals, physicians and other providers that would have created efficiencies that benefited the consumer. I believe the answer to both of these questions is that on the whole competition does work and that antitrust enforcement has not deterred procompetitive collaborative efforts. The "perception" issue—by its very nature—is more difficult to address. To the extent that procompetitive collaborative efforts did not occur because of the fear of antitrust enforcement, a benefit has been lost. But, I believe, that that perception problem, which is inherent to all laws not just antitrust laws, will diminish as the interaction of health care reform and our antitrust laws become clearer.

As I thought about my testimony today, I struggled with the difficulty of addressing briefly and clearly the application of our antitrust laws to the health care industry. After all any body of law that has as its guiding principle something called the "rule of reason" does not lend itself to restatement. During the century since the Sherman Act was enacted, our antitrust principles largely have been developed judicially in cases unique to their own facts and circumstances. Nevertheless, certain clear principles have emerged over time and the antitrust laws are best understood

with reference to their underlying purpose—that is, to protect consumers from the exercise of market power thereby ensuring efficiency, consumer choices and the lowest possible prices.

But how does that apply to the delivery of health care services? I think the answer is as follows. Competition—and for that matter health care reform—seeks to protect consumers from market power. Market power in the hands of sellers is what restricts output (i.e. choices) and increases prices. Yet our health care system would benefit from efficiencies generated by increased collaboration by and between providers. The key issue is how to ensure that the efficiencies are passed on to consumers in the form of better service and quality with lower costs. There are but two ways to ensure that efficiencies will be passed on to consumers. Some sort of government watchdog could be created to police the industry by setting its rates. But I do not believe that "policing" over time can work and it, in and of itself, is expensive. The alternative solution to create a health care industry where competition ensures that consumers are the ones that benefit from collaboration. For competition here means nothing more than giving choices to consumers. Thus, I respectfully suggest, the paradigm we follow is to encourage collaborations that produce efficiencies, but only to the extent that after the collaboration is established there are enough choices to ensure that consumers will benefit from the efficiencies. I confess that this is a balancing act, but as discussed in my statement, it is doable—in fact it is being done as we speak.

Hospitals and physicians should be commended for the enormous amount of efficient collaborative efforts that are either contemplated or underway. Over the past several years over 200 hospitals have merged, there has been an explosion of hospitals sharing and working together and there has been a phenomenal growth of physician integration. Thus, a great deal of efficiencies already have been achieved and will be achieved in the future.

This is an enviable record. Particularly since hospitals and physicians are reforming a system that we as a society insisted upon. I have been a hospital trustee for a number of years and I am proud of the community service that hospitals provide. It should be recognized that if our hospitals today are inefficient with too much capacity, it is because that is what we as a society demanded. Regardless of cost, we wanted neighborhood hospitals providing virtually all services 24 hours a day seven days a week. Now we as a society say it is too expensive. Maybe it is, but we asked for it.

But the health care industry is reacting to our changing demands. Health care costs are being controlled by managed care. That- system of health care purchasing called managed care ensures that the efficiencies will be passed on to the consumer. For your interest, attached to my statement are two recent magazine articles on the growth of integration and the effect of managed care in reducing spiraling health care costs. Also attached is a copy of a chart showing that health care costs may be increasing *less* in markets with managed competition than in markets with rate regulation.

A. INTRODUCTION

Although the precise form that health-care reform will take has not been decided, it appears clear that it will include the so-called "managed competition" concept. For purposes here, "managed competition," in broad terms, contemplates a system of selling, buying, and financing health-care goods and services by large purchasing cooperatives, called "Purchasing Alliances," which purchase health-care goods and services for individuals, small businesses, and perhaps others from groups called "Accountable Health Plans" ("AHPs"), which may combine the financing and delivery function. AHPs will compete against one another based on numerous competitive variables, including price.

This focus of this statement is on the potential antitrust ramifications from the formation of AHPs or integrated delivery systems. AHPs could take several forms. For example, the delivery and financing functions could be fully integrated as in a Kaiser-type system, which would include financing, hospital services, medical services, and other types of health-care goods or services within in a single entity. Or, the AHP could resemble a group or IPA-model HMO, whereby the AHP entity, while financing and coordinating health-care services, contracts for their provision with providers. The AHP would be capitated and would compete with other AHPs for the patronage of HIPCs and perhaps other large purchasers of health-care goods and services based on price and quality. The AHP might reimburse its providers on a capitation, fee-for-service, or other basis.

Regardless of whether an AHP is fully integrated unit or whether it contracts with other units for goods or services, it seems clear that the formation of AHPs

contemplates at least four types of economic integration with potential antitrust ramifications:

(1) at the local level, the horizontal integration of competing physicians, particularly primary-care physicians, into fully or partially integrated units;
(2) at the regional level, the integration of hospitals, some of which will be competitors, into fully or partially integrated units called, for example by the AHA, community care networks;
(3) the integration of hospital and medical services through the formation of fully or partially integrated entities of hospitals and physicians;
(4) the integration of financing and delivery by contractual arrangements between non-fully integrated AHPs that contract with providers for the delivery of health-care goods and services.

Each of type of integration has potential antitrust implications, particularly under section 1 of the Sherman Act, which prohibits agreements unreasonably restraining competition, and section 7 of the Clayton Act, which prohibits business consolidations that may substantially lessen competition.

I believe that, because the agreements and combinations that would result in the formation of AHPs would almost always be tested under antitrust's flexible "rule of reason" rather than under its "per se rule," the antitrust laws should not be a substantial deterrent to the formation of AHPs.

B. HORIZONTAL INTEGRATION

Horizontal integration—that is, integration among competitors—raises antitrust concern because of the fear that competitors, acting together, may be able to exercise market power. On the other hand, the Department of Justice's Antitrust Division, Federal Trade Commission, and state attorneys general, as well as courts, recognize that horizontal integration also can result in substantial productive efficiencies—the production of greater output using fewer resources. Where both of these effects result, the rule of reason mandates that they be balanced to determine which predominates.

1. Horizontal Integration Among Competing Physicians

In the managed-competition scenario, competing physicians may integrate their practices into a fully integrated AHP or they may integrate their practices into units that contract with the AHP. Their integration may be complete, as when they merge into a single group, such as a group practice or single clinic-without-walls, or it may be partial, as when they form an IPA-type organization that leaves them free to participate in other similar organizations.

Complete integration through merger is subject to section 7 of the Clayton Act. The federal enforcement agencies would apply their *Horizontal Merger Guidelines* to determine whether to challenge the merger. Relevant markets would be defined, post-merger concentration calculated, and, if concentration were sufficiently high to create concern, other factors are examined to determine whether the merger actually is likely to substantially reduce competition. These would include, in particular, the level of entry barriers into the market and efficiencies generated by the merger.

Inasmuch as antitrust analysis, and particularly merger analysis, is fact-specific, it is impossible to determine, *a priori*, the degree of antitrust concern that physician practice mergers in establishing AHPs would generate. The federal agencies, however, examine all facets of the market, not just the degree of post-merger concentration, in determining whether a particular merger warrants challenge. The agencies would be concerned especially about a physician merger that provided either an AHP or a physician group contracting with an AHP with significant market power. In the context of managed competition, however, the agencies carefully would consider the effect of the managed-competition environment on the merger's likely effect on competition. Specifically, the agencies would consider efficiencies generated by the merger, the extent to which the merger helped the AHP to compete more effectively against similar entities, the ability of Purchasing Alliances (whether because of their size or regulatory powers) to constrain the AHP's or physicians' ability to exercise market power, and other similar practical variables based on the specific facts.

Partial integration, such as the formation of an IPA-type entity that would contract with the AHP, would be assessed under traditional antitrust standards applying to joint ventures. Here, the most important variables probably would be the percentage of competing physicians in the geographical area participating in the entity, whether they were prevented from participating in other similar entities (by, for example, exclusive contracts), and whether they were placed at-risk through, for example, a capitation arrangement. The rule of reason would apply, and the agency

or court would consider procompetitive effects (efficiencies, greater geographical coverage, and the like) flowing from the arrangement.

2. Horizontal Integration Among Hospitals

The managed-care environment appears to contemplate complete or partial integration among hospitals into regional networks. This could include mergers among competing facilities, various types of joint ventures, and simple agreements allocating services or reducing duplicative services.

As to mergers, the agencies would apply their *Merger Guidelines.* Although hospital markets, unlike physician markets, typically are highly concentrated, the agencies would continue their practice of moving beyond concentration figures and attempt to predict whether other factors indicated that the merger was unlikely to substantially lessen competition. History thus far indicates that most hospital mergers are not objectionable under the antitrust laws. Either they fail to create market power or they otherwise generate offsetting efficiencies. Most challenges have involved mergers resulting in very high post-merger market shares, but on the other hand both agencies have passed on mergers resulting in concentration well above the *Merger Guidelines'* concentration "safe harbors." A number of hospital mergers have escaped challenge on the ground that despite the high market shares the merged hospital would not have market power or that the merger generated substantial efficiencies.

Nonetheless, it appears that many hospital mergers that health care reform might contemplate could raise serious antitrust problems unless Purchasing Alliances or some other force were able to constrain the hospitals' ability to exercise market power. If, after the merger, there are sufficient independent hospitals to support the formation of several AHPs, then the transaction should not warrant challenge absent unusual circumstances. The key is to foster competition among AHPs.

Antitrust enforcement agencies, thus far, have found few competitive problems with hospital joint ventures. Indeed, neither federal agency has challenged one. On the other hand, certain types of agreements among competing hospitals could raise serious problems under the antitrust laws. In particular, market-allocation agreements and agreements to reduce perceived unnecessary duplication are arrangements of the type that frequently has been condemned, at least in other industries, under the per se standard and prosecuted criminally.

Under health care reform's managed competition many of these types of agreements have the potential to generate substantial efficiencies and thus should be analyzed under the rule of reason. Perhaps if faced with the issue, the agencies and courts would apply rule-of-reason analysis. The agencies could issue jointly, like they did with the *Merger Guidelines,* a statement of how they would analyze such arrangements. They may even consider guidelines that establish a safe harbor whereby compliance with it would ensure rule of reason analysis and no criminal enforcement. Of course, the danger of safe harbors or bright line tests are that otherwise lawful conduct is discouraged. Perhaps for an introductory period of time the agencies could establish an efficient, relatively quick and non-mandatory procedure (like research joint ventures) whereby parties to such arrangements voluntarily could submit them to review. If the guidelines and/or agency review process were followed, then parties to these arrangements could be protected from criminal enforcement and/or private treble damage suits.

C. NON-HORIZONTAL INTEGRATION

All else equal, non-horizontal integration, which by definition, means integration among non-competitors, raises fewer antitrust concerns than integration among competitors. Because those integrating are not competitors, there is less likelihood that the integration will increase market power. Non-horizontal integration, however, is not antitrust risk-free primarily because it can foreclose markets to competitors. In addition, the non-horizontal integration discussed here, among hospitals and physicians, usually results in horizontal integration as well, and thus many of the principles discussed before may apply.

1. Physician-Hospital Integration

A major tenet of managed competition is that hospitals and physicians will integrate their delivery of services. This could occur in several ways, including: (1) hospital employment of physicians; (2) formation of physician-hospital organizations ("PHOs"); (3) use of management-service organizations ("MSOs"); or (4) formation of foundations or similar types of organizations.

Typically the employment of physicians by hospitals raises few antitrust concerns. One potential problem, in quite limited circumstances, is substantial foreclosure. This could occur, for example, if a hospital employed such a large percentage of "big

admitters" that other hospitals were foreclosed from a substantial percentage of potential patients. Similarly, a hospital might employ such a large percentage of physicians in a given specialty that other hospitals were unable to offer the types of hospital services complementary to that specialty. Because, however, hospitals often are not able to recruit physicians easily, these effects seem unlikely.

Integration between hospitals and groups of physicians, such as the hospitals' medical staffs through a PHO, require both horizontal integration (that is, integration among members of the medical staff) and non-horizontal integration (between the hospital and medical staff). Thus, the principles relating to horizontal integration discussed above apply. Perhaps most important are whether the physician component of the integrated entity will be able to exercise market power and whether the reimbursement methodology of the physicians constitutes a horizontal price-fixing agreement.

It seems doubtful that the hospital's integration with its medical staff (the non-horizontal aspect of the integration) raises significant antitrust problems. This is especially true if the participating physicians remain free to participate in other networks, including those sponsored by other hospitals. A problem could arise if the physician component included a large percentage of competitors in the area and physician members were prevented from participating in other networks and plans.

2. Integration Between Non-Fully Integrated AHPs and Providers

AHPs that do not integrate providers into a single entity will contract with providers or provider groups to render necessary health-care services. This type of relationship, in two types of limited circumstances, can result in a foreclosure problem.

First, if AHPs contract selectively for limited panels, rather than with "all willing providers," some providers will be excluded from the plan and, if no alternatives exist, foreclosed from the market. For this to occur, however, the AHP must have substantial market power. Moreover, that some providers might be foreclosed from the market does not necessarily mean that competition will be unreasonably restrained. Sufficient competitors may remain for the market to be competitive. Contracting selectively may permit the AHP to obtain better prices or other terms and conditions of sale because the patient volume of the selected providers is increased. Selective contracting, indeed even exclusive contracting, is tested under antitrust's rule of reason and rarely should generate antitrust concern.

Second, if providers or provider groups contract exclusively with a single AHP and refuse to contract with competing AHPs, then the latter may find it difficult to find the necessary providers for them to compete effectively. For this to be a potential problem, however, the provider group entering into the exclusive arrangement would have to include a substantial percentage of the competing providers in the area. Otherwise, competing AHPs could simply contract with providers not part of the exclusive arrangement. This type of exclusive arrangement also is tested under the rule of reason and should raise antitrust concern only infrequently.

D. CONCLUSION

In sum, the antitrust laws should not deter formation of integrated delivery systems. Antitrust's rule of reason appears sufficiently flexible to permit arrangements—even those that superficially resemble restraints on competition—that promote managed-competition or other arrangements that promote efficiency. It does appear, however, that enforcement agencies and courts may have to adjust their thinking to the new economic environment resulting from implementation of managed competition. And it would be helpful to develop guidelines on how to analyze these arrangements and, perhaps for an introductory period of time, to develop a voluntary, inexpensive and timely agency review process. If the guidelines and/or agency review process were followed, then parties should be protected from—criminal enforcement and/or private treble damage suits.

Attachments.

Health Prices Tend To Rise Faster in Regulated Markets Than in Competitive Markets

- The Health Care Financing Administration pays health maintenance organizations (HMO) a monthly per enrollee amount calculated on the basis of county/city fee-for-service spending.
  - -- The payment is known as the "Average Adjusted Per Capita Amount," or AAPCC.
  - -- The AAPCC is adjusted for demographic (age, gender) differences between counties/cities.
- Market-to-market differences in AAPCC growth rates reflect differences in inflation and utilization trends.
  - -- Certain areas -- Maryland, New York, and New Jersey -- have long regulated health prices closely.
  - -- Other areas -- L.A., S.F., and Minneapolis -- are unregulated and have a high HMO penetration.

Regulated Areas	1990 AAPCC	1993 AAPCC	Percent Change
Baltimore, MD: County	$391.92	$510.47	30.2%
Baltimore, MD: City	$336.09	$424.33	26.3%
New York, NY: City	$442.89	$544.00	22.8%
Mercer, NJ: County	$334.10	$410.43	22.8%
Essex, NJ: County	$369.38	$439.20	18.9%
Regulated Average	*$374.88*	*$465.69*	*24.2%*

Managed Care Areas	1990 AAPCC	1993 AAPCC	Percent Change
Los Angeles, CA: City	$432.07	$515.28	19.3%
Orange, CA: County	$411.54	$493.60	19.9%
San Francisco, CA: City	$392.35	$444.08	13.2%
Alameda, CA: County	$379.17	$432.38	14.0%
Hennepin, MN: County	$313.02	$353.07	12.8%
Ramsey, MN: County	$324.20	$357.08	10.1%
Managed Care Average	*$375.39*	*$432.58*	*15.2%*

Source: "Impact of Provider Rate Regulation on HMOs: A PULSE Analysis," Sherlock Company, January 1993, P.O. Box 413, Gwynedd, PA 19436

HOSPITALS ARE MAKING FEWER PURCHASES OF ELABORATE HIGH-TECH MEDICAL EQUIPMENT

SURPRISE! HEALTH CARE'S FEVER MAY HAVE FINALLY BROKEN

The $900 billion industry is now yielding to price pressures

William C. Bopp, like many of his peers, calls it "the Clinton effect." With Hillary Rodham Clinton's health-care task force floating a new trial balloon every week, an amazing thing is happening to rising medical costs: They're slowing down. Dramatically. For Bopp, chief financial officer at New Jersey-based medical supply company C R Bard Inc., that means his company's normally double-digit sales growth will also decline. Dramatically.

Hillary might well take the credit, but it's not just Washington's orchestrated attacks on drug companies, insurers, and doctors that has the health-care industry running for cover. Credit also goes to the cost-cutting efforts of such top employers as Xerox Corp. Toss in the salutary effects of disinflationary forces on a weak economy, and you've got a raft of emerging signals that the rate at which medical costs rise is easing. If the decline persists, it would be just the right medicine for a nation that spends 14% of its gross national product on health care.

The most recent evidence came in the March consumer price index, which showed a rise in medical costs of just 0.3%—the lowest monthly uptick in nine years. The March numbers are part of an accelerating trend in recent years, in which health-care cost increases have slowed to an annual rate of below 6%, from a peak of 9.6% in 1990. Fees for doctors and other health-care professionals, in particular, grew at an annual rate of 4.3% in the first three months of the year. That's the slowest growth rate since the early 1970s.

Many in the health-care world say market forces finally are moving the $900 billion industry to action. A few years ago, providers had little incentive to control costs—employers just paid the tab, with few questions asked. But the advent of purchasing groups for hospitals that negotiate discounts, cut-rate drug resellers, and medical-network managers who scrutinize doctors are reshaping the industry (page 104). Now, "the government proposal is a sideshow," says Jean-Pierre Garnier, North American president of SmithKline Beecham PLC. "The trends of managed care in the market are far more powerful."

THE HEAT IS ON. Recent surveys show that managed care—in which roughly half of all private-sector workers participate—is indeed having a dramatic effect on costs. Consultants A. Foster & Higgins Co., for one, found that health benefits per capita cost Corporate America an average of $3,968 in 1992. That's a 10% increase over 1991, but the lowest year-to-year hike in five years. Increases for traditional fee-for-service coverage were higher, at 14.2%. But costs for workers enrolled in managed-health plans rose just 8.8%.

The health-care business can't help but feel the heat. Just ask Syntex Corp. On Apr. 12, it joined other pharmaceutical makers in agreeing to hold future price hikes to barely above inflation. For years, Syntex had taken increases of 6% to 10% in its best-selling products. Then there's U.S. Surgical Corp., which on Apr. 8 saw the value of its stock sink 33% after announcing that second-quarter earnings would nose-dive as it shifted from direct sales to a distribution system that will cut into profit margins.

Or look at the nation's health insurers. In the next five years, fierce competition will reduce by one-third the 750-odd companies that offer medical insurance, says A. M. Best & Co., an industry rating agency. Those remaining will do business very differently. CIGNA Corp.'s health-care arm, for instance, has turned to top health-maintenance organization U.S. Healthcare for new leadership to rev up its operation.

In fact, the health-care industry is now getting the same medicine that hit the airline and automobile industries: Those that want to survive had better learn to produce more for less. Says Angelo T. Lapriore, purchasing manager for Boston's Beth Israel Hospital: "We're drawing a line in the sand in terms of price increases."

Such attitudes are becoming prevalent throughout the industry. At Xerox, benefits

BRACING FOR THE NEW HEALTH-CARE WORLD

Market forces are driving change across the industry

INSURERS Small insurers are fighting to control costs. Bigger companies are beefing up networks of medical providers. Others are carving out niches that may survive reform.

MEDICAL SUPPLIERS Equipment manufacturers are cutting costs and shifting to distributors. They're targeting international markets and promoting cost-efficiency.

DRUG COMPANIES Stung by attacks on their high prices, drugmakers are vowing to limit price hikes to barely more than the rate of inflation. Some are shifting into generic products.

HOSPITALS With empty beds and huge overhead, hospitals are paring inventories, forcing suppliers to use wholesalers, and joining purchasing groups to negotiate discounts.

DATA: BUSINESS WEEK

director Patricia M. Nazemetz is determined to keep the 185 health-maintenance organizations that serve her employees in line. "We're asking them to justify anything above a 5% cost increase," she says. South Miami Health System, a 525-bed hospital, is switching to an inventory system that will keep no more than a 24-hour supply of some noncritical items. CEO John Geanes also is combining the purchasing operations of South Miami with a 125-bed sister hospital in Homestead, Fla. The first year's cost savings from both moves: $600,000.

The decline in medical spending could jolt smaller, fast-growing companies that make medical equipment. On top of pricing pressures, the Administration may dissuade hospitals from investing in new technology. For years, companies such as U.S. Surgical and Cordis Corp. have prospered by bringing ever-new products to market. "We built our company on new technology, and until this gets straightened out, we're going to have lean times," says Surgical Chairman Leon C. Hirsch.

But the new competitive pressures could be a boon to some industries. Humana Inc., a big health-plan operator, is expecting to expand rapidly, says Chairman David A. Jones. In March, he doubled his stake in Humana—an investment worth some $20 million.

The changing marketplace has not gone unnoticed in Washington. An Administration official says the recent slowing of medical inflation suggests "the reform effort is going in the right direction" in embracing the idea of managed competition. "These figures show that insurers and providers respond to price pressures," the official adds.

But will Washington soften its plan to accommodate price pressures that go down as well as up? Don't bet on it. The Administration official acknowledges that no one on the health-care task force had called for a briefing on the CPI report. Clinton was elected, in part, by preying on fears of ever-rising health-care costs. Those costs may be ebbing, but political imperatives can often be more important than economic ones.

By Tim Smart, with Chris Roush in New Haven, Gail DeGeorge in Miami, and bureau reports

SOMETHING FOR EVERYONE—EXCEPT THOSE WHO FOOT THE BILL

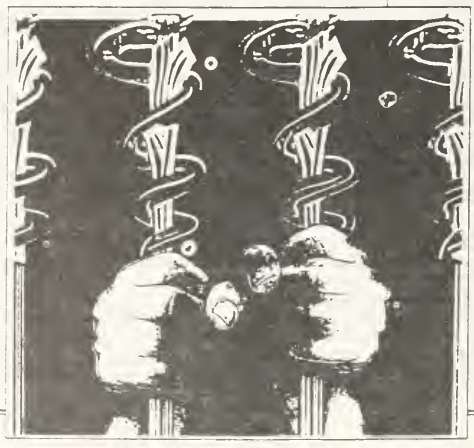
Back in 1910, Montgomery Ward & Co. offered its workers one of the first group health-insurance policies—and helped launch a revolution. Employer-provided insurance now dominates American medicine: Companies pay more than $200 billion a year to buy care for 150 million workers and their dependents, or 60% of the population. The system worked just fine until medical costs exploded in the 1980s, forcing employers to tweak and trim benefits in a desperate attempt to cut their payouts.

The Clinton Administration's health-reform package is supposed to rein in those costs—but the solution may also cost business virtually all of its current role in health care. Under the blueprint sketched by top White House health aides on Apr. 9, employers would have just one job: paying the bill.

CASH PUMPS. Unlike today, employers would have little say about the benefits they fund. Health plans would meet federal guidelines. And benefits would not depend on having a job. Instead, consumers would sign up at local "health alliances," large purchasing groups set up by states to negotiate coverage with networks of providers. The new system could largely turn businesses into a "pumping station for money," says Princeton University economist Uwe E. Reinhardt.

Is this progress? It depends on who you ask. Clinton's reform team calls its plan "health security," ensuring that all Americans have consistent coverage. And the proposals are just fine with some big companies—especially those with older, unionized work forces—that are eager to dump burdensome health plans. "We're fairly sure that we'd benefit from putting our people into the alliances," says Walter B. Maher, Chrysler Corp.'s director of federal relations.

But some big employers say that they're already reining in costs and can do that better than the government. And, they say, they don't want their employees forced into "alliances" that haven't yet been tested. "It sounds like a lot of potentially damaging ideas are being floated," says Vance J. Anderson, assistant general counsel of AlliedSignal Inc. "If there's one area in health care that's working, it's the employer-sponsored plans."



Clintonites claim the changes will make the system fairer. Their reform model, called managed competition, would indeed provide a boost for small companies by pooling their workers with Medicaid recipients and others in a big buying group. Besides the enhanced buying clout, the pools would relieve small fry of the administrative costs and premium hikes they now face if they buy coverage.

But some big employers—who already have the muscle to win discounts—didn't expect the rules to apply to them. Now, White House aides say the scheme may require all companies to send workers to alliances. Even if some companies—probably those with 500 or more employees—can opt out of the alliances, the Administration would make it so tough that few would do so.

Clinton is betting that his pitch to consumers—secure coverage with lots of choices—can drown out business' complaints. "It's vintage Clinton—something for everyone," says Gordon Wheeler, director of federal affairs for the Health Insurance Association of America. Everyone, perhaps, except those who pay the bills.

By Mike McNamee in Washington

COVER STORY

Doctors' orders: Integrate

Physicians maneuvering to secure a key role in systems expected to dominate under reform

By Della de Lafuente *Los Angeles bureau chief*

With healthcare reform looming, physicians in private practices are bracing for the worst while those entrenched in physician-dominated integrated delivery systems are more optimistic.

Many of the physicians involved in integrated systems are hoping for professional satisfaction, economic well-being and abundant opportunities to bring high-quality medical care to their patients.

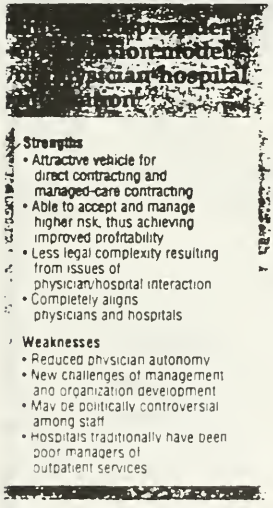
Analysts believe integrated delivery systems—which offer acute care, physicians' services, insurance and other medical support programs under a parent organization—will dominate the industry after reform.

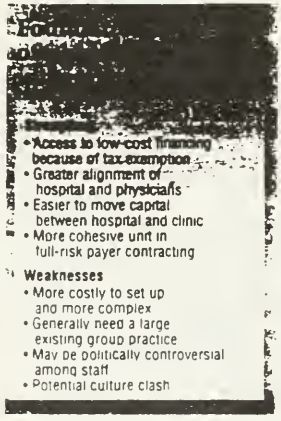
Some healthcare executives seeking to gain an edge over their competitors already are recognizing the need to bring more primary-care physicians into the fold. Multispecialty groups also are recognizing the importance of beefing up the nation's pool of primary-care physicians, particularly in underserved areas.

Primary care reigns. Medical groups realize that primary-care physicians help their organizations grow and will protect their referral base in the likely event healthcare reform erodes the importance of specialty care.

In recent months, executives of medical groups ranging from the internationally known Cleveland Clinic Foundation to the regional Friendly Hills HealthCare Network in La Habra, Calif., have emphasized recruitment of primary-care physicians.

A unique agreement between the Cleveland Clinic and Kaiser Permanente of Ohio allows the health maintenance organization's physicians to care for its 200,000 enrollees at the clinic's hospital.





Friendly Hills, a multispecialty group practice of about 160 physicians, is engaged in "bidding wars" with hospitals, HMOs and other physician groups over the new crop of primary-care physicians, a spokeswoman said.

San Diego-based Sharp HealthCare System has been building its physician network since the mid-1980s. During that time, Sharp-Rees-Stealy Medical Centers formed a corporation within the Sharp system to acquire the assets of the Rees-Stealy physician group, a 275-physician multispecialty group founded in 1923, and Sharp Community Medical Group, a 435-multispecialty group (See related story, p. 31.)

Earlier this year, Sharp HealthCare formalized an affiliation agreement with Mission Park Medical Clinic, an 88-physician primary-care group practice in Vista, Calif. Mission Park operates five family practice, pediatric and urgent-care clinics in the San Diego area.

Physicians joining an integrated system reduce their medical practice costs while more effectively competing with other integrated systems for prepaid managed-care contracts. Physicians' expansion plans, previously restricted by a limited service area, gain clout through a system's expanded market reach and deep pockets.

Medical-group makeover. Harriman-Jones Medical Group, a 70-physician multispecialty group in Long Beach, Calif., is redesigning itself by branching into primary-care medicine and joining an integrated system.

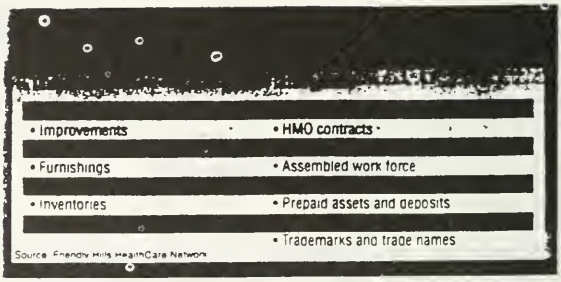
Acquired by Burbank, Calif.-based UniHealth America last year, Harriman-Jones is awaiting a ruling by the Internal Revenue Service that will determine whether it can become a not-for-profit, charitable foundation under Section 501(c)(3) of the federal tax code.

UniHealth's request for tax-exempt status for the acquisition of Harriman-Jones is the second for the health system. Last month, the IRS granted a tax-exemption request permitting UniHealth to acquire 78-physician Facey Medical Group, a multispecialty practice in Mission Hills, Calif. (April 12, p. 16).

Creation of the foundation would allow Harriman-Jones to relinquish all assets of the practice to UniHealth, which operates 11 not-for-profit hospitals as well as two HMOs, CareAmerica and PacifiCare.

Touted by experts as an ideal method of delivering medical services, integrated or "seamless" systems combine medical group practices, which offer primary or specialty care, with hospitals, medical clinics/offices and some form of prepaid health insurance program.

The separate organizations operate



under the same corporate umbrella, which negotiates package deals with healthcare purchasers and payers that prefer to contract with a single entity instead of multiple groups.

And as physicians, hospitals and insurers seek to establish well-financed provider networks through extensive, prepaid managed-care contracts, a rapid restructuring and consolidation is occurring across the country.

Preparing for reform. Some experts believe integrated systems will help hospitals and physicians in the systems stay a step ahead of the vast changes expected to emerge from healthcare reform. Physician groups that reject the idea of integrated systems in favor of fee-for-service healthcare are living in the past, the experts say.

"The golden age of medicine—an idealized idea of how medicine could work—has passed," said David Ottensmeyer, M.D., president and chief executive officer of the Lovelace Medical Foundation in Albuquerque, N.M., at a recent meeting of health systems, physicians and physician groups in Aspen, Colo.

"The world in which there's an endless supply of resources from third-party payers and employers has changed," he said, noting, "physicians will need new skills and expertise" to survive in a rapidly changing field.

However, some physicians have condemned vertical integration as a plot by hospitals to strip them of their autonomy. They view healthcare reform as the decline of their profession and the start of reduced incomes, increased patient loads and compromises in the quality of care.

California competition. The push to achieve integrated systems has reached a frenzied pace in California, where systems are busy forming and expanding with one goal in mind: competing with HMO giant Kaiser Permanente, which operates in 12 regions covering 16 states.

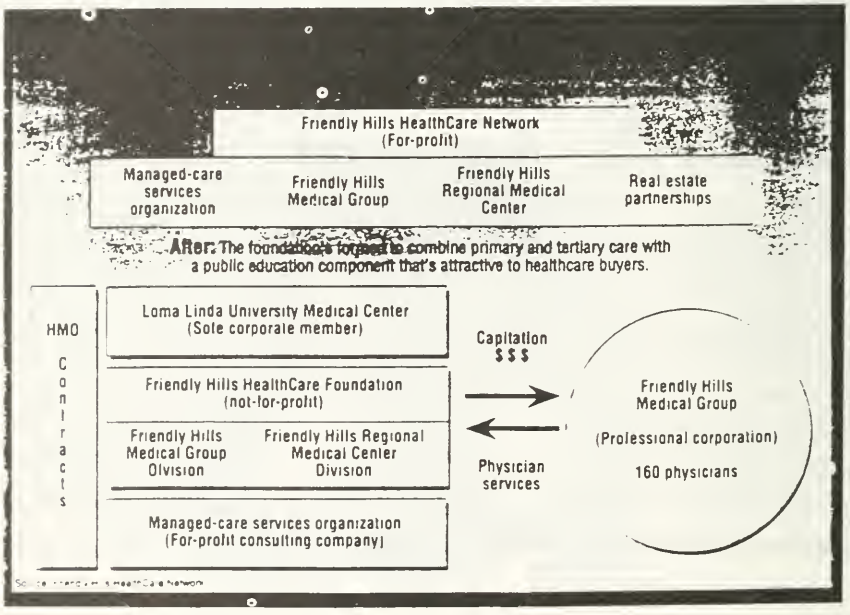
One multispecialty physician group seeking to improve its competitive edge, and grab a piece of the Kaiser pie, is the newly formed Friendly Hills Medical Group. It was formed when Friendly Hills HealthCare Network received IRS approval to convert its for-profit multispecialty group to a tax-exempt, 501(c)(3) foundation.

Earlier this year, the IRS awarded the tax-exempt status to Friendly Hills in what is considered an important breakthrough for integrated delivery systems (Feb. 15, p. 2).

The IRS determined that Friendly Hills qualified as a tax-exempt public charity because the foundation will be operated for the benefit of the community, not for the private benefit of physicians.

Industry experts said it indicates the IRS will look favorably on not-for-profit foundations owning integrated networks if such systems demonstrate they benefit the community by providing cheaper

Continued on p. 31



San Diego group practice goes shopping for a partner, becomes target in bidding war

Paul Reeb, M.D., a primary-care physician and president of the Sharp Community Medical Group in San Diego, said he saw the writing on the wall about five years ago.

Dr. Reeb, then a physician in private practice, recognized that healthcare payers were becoming selective about providers, preferring to do business with physicians who were part of large group practices that conducted their own utilization review.

That's when Dr. Reeb decided to take the plunge into managed care along with 30 other primary-care physicians in the San Diego area, forming the Sharp Community Medical Group. Originally, the founding group operated under the name Sharp IPA, which included physicians who had admitting privileges at Sharp Memorial Hospital. It now has 135 primary-care physicians and about 300 specialists who provide care at 100 sites in San Diego County.

"It was a matter of recognizing that the only thing permanent (about the healthcare delivery system) is change," Dr. Reeb said. "We really were forced to rethink our futures."

Many of the physicians also saw it as a matter of survival, with concerns rising about burdensome paperwork, malpractice insurance, shrinking reimbursements and the loss of patients to physicians who provide prepaid healthcare. Dr. Reeb and his physician group went shopping for a major healthcare system affiliate in 1989.

Dr. Reeb

The medical group became a hot property that was sought by San Diego-based Sharp Healthcare System and its competitors, Mercy Hospital and Medical Center in San Diego and Scripps Memorial Hospitals in La Jolla, Calif.

"Any time you have a significant group of primary-care physicians, everybody wants to get their hands on them," Dr. Reeb said. "Hospitals, health maintenance organizations and other medical groups want to sign them and gobble them. We could have negotiated with whomever we chose."

Various offers and counteroffers were extended to the medical group, but the decision was clear, said Dr. Reeb, although he didn't reveal why the other offers failed to meet the group's expectations.

"Because we had a keen sense of the amount of business we could give (a healthcare system), we sought a relationship that gave us a sense of having equal footing with the administration," he said. "We chose our partner carefully because we don't want a divorce (in the future)."

In the end, Sharp beat out the other bidders largely because of its "broad geographic reach, economic clout in negotiating package healthcare deals and collaborative team approach," Dr. Reeb said. An important aspect of the deal was that Sharp gave the medical group much-desired autonomy. "Sharp never sought to buy us outright," Dr. Reeb said. The practice signed a loose affiliation agreement in which medical group practice members agree to provide care for patients from Sharp Healthcare.

Stephen Salisbury, senior vice president of network development for the Sharp system, said physicians have two choices. They can participate in the future or continue practicing in a healthcare system of the past.

Since the mid-1980s, Sharp has asked physicians to join it in developing an integrated system, which it has created by adding various medical groups, including Mission Park Medical Group, acquired last year.

"The (health) system's future also depends on the relationships we forge with physicians," Mr. Salisbury said.

—Della de Lafuente ■

Continued from p. 26

care to a large number of people. It's also a signal that the IRS has recognized the value of combining primary-care physicians with an academic institution as an effective mode of healthcare delivery.

Under Friendly Hills' foundation model of integrated healthcare, the 160-physician multispecialty group will sell its hospital and other assets for $125 million to the not-for-profit foundation it's establishing with Loma Linda (Calif.) University Medical Center.

The transaction will be financed through an $80 million tax-exempt bond issue, a $30 million, 10-year installment note and $15 million from physicians.

Albert Barnett, M.D., chief executive officer of Friendly Hills Network, said the sale will help permit the physician partners to raise money for expansion, forge a closer relationship with 610-bed Loma Linda and recruit new physicians.

Friendly Hills Medical Group will sign an agreement with a new not-for-profit corporation to provide physician services as an independent contractor (See chart, p. 26). That is, the medical group will be employed under contract by the corporation. Such a contract is necessary because California law prohibits the corporate practice of medicine.

Since it was established in 1968, Friendly Hills Medical Group has become a major provider in northern Orange County, Calif. Its primary-care-driven system has been designed to operate efficiently with a single administrative arm for both its hospital and medical group. Some 95% of Friendly Hills' patients are covered by health plans that pay capitated rates for both hospital and physician care. About half of its physicians are in primary care.

Friendly Hills provides care through its hospital and 10 clinics for 100,000 enrollees in 18 prepaid health plans.

Another newly formed integrated system with designs on tapping Kaiser's key market is the relationship forged by Catholic Healthcare West in San Francisco and Hill Physicians Medical Group in San Ramon, Calif. (March 22, p. 4).

To help win new contracts, both organizations announced a plan to share in ownership of PriMed Management Consulting Services, a medical management company, which will manage a regional, integrated healthcare system designed to attract group purchasers.

If the new venture is successful, the network expects to pose a threat to Kaiser, which has 3,200 physicians and 1.7 million enrollees in its Northern California HMO.

Richard Kramer, president and CEO of Catholic Healthcare West, said the alliance is part of a strategic plan the system has launched to expand its presence in the San Francisco area.

The relationship with Hill will give the system access to the medical group's extensive network of 800 primary- and specialty-care physicians in Alameda and Contra Costa counties, Mr. Kramer said.

Meanwhile, Foundation Health in Sacramento, the second-largest HMO in Northern California, is waging war on Kaiser with an integrated system.

Foundation plans to open three medical clinics in Sacramento that would form a network of 30 primary-care physicians. (March 29, p. 24). The clinics will provide family practice, internal

medicine and pediatric care.

Adding the clinics also will put Foundation's HMO head-to-head with outpatient clinics and physicians tied to Sutter Health and Mercy Healthcare in Oakland and Sacramento.

Foundation spokesman Kurt Davis said rapid growth in the past 18 months has left the HMO with shortages of primary-care physicians in some sections of Sacramento. As a result, salaries for primary-care physicians have risen about 5%, according to information provided by the Medical Group Management Association in Englewood, Colo.

Starting salaries for primary-care physicians at Kaiser vary by specialty but can start at $75,000 and top $100,000 for primary-care specialties such as obstetrics, the company said.

In contrast, MGMA reported that in 1991, primary-care physicians in medical group practices of 10 or fewer physicians, earned an average salary of $89,213 and family practice physicians in groups of 51 or more earned an average $105,913 (See chart, this page).

In the past, Foundation has relied largely on a network of 930 primary-care physicians and 2,800 specialists in private practice and community hospitals to provide care for its Sacramento-area enrollees through various contractual arrangements. Foundation has 180,000 enrollees in Sacramento and 450,000 enrollees and 12,000 physicians statewide.

However, Kaiser, at least for the moment, appears undaunted by the growing competition.

L. Jerome Ashford, a Kaiser vice president and health plan manager, said his company's group model, which others strive to emulate, isn't threatened by the emerging competition. "It's definitely keener, but we know we have more to offer," he said.

Cooperating with Kaiser. Unlike plans by Friendly Hills, Hill Physicians and Foundation Health to take on Kaiser, one large multispecialty group practice has decided to form a partnership with the huge HMO.

The Cleveland Clinic Foundation, a multispecialty group of 500 physicians, has signed an agreement with Kaiser Permanente of Ohio that calls for the HMO to steer its 200,000 enrollees to the clinic. In return, the clinic will designate a number of its 900 beds for Kaiser enrollees.

John Clough, M.D., Cleveland Clinic's health affairs chairman, said Kaiser physicians have gained admitting privileges at the clinic so they can perform surgeries and treat patients there. The clinic began treating Kaiser patients earlier this year. Although a legal challenge by Cleveland-based MetroHealth System still remains, a full transition of patients may come at the clinic by Jan. 1, 1994. MetroHealth is seeking to prevent Kaiser from sending patients to Cleveland Clinic before its contract expires in 1995.

	1991	1990	1989
10 or fewer physicians	$89,213	$84,712	$89,250
51 or more physicians	$105,193	$101,449	$96,804

* Doesn't include medical benefits or retirement benefits
Source: Medical Group Management Association

Mr Ashford

Dr Barnett

Mr Kramer

During the 1980s, physicians at the clinic chose to stay out of the managed-care business. But a newly revitalized managed-care and payer relations department has been signing up big-name national and regional health insurers that want the internationally known hospital to handle complex medical problems for their enrollees.

For instance, on March 1, Atlanta-based Delta Air Lines formalized an agreement naming the clinic one of six medical centers nationally that will serve as a cardiac specialty provider for its employees and their dependents.

Cleveland Clinic executives said the goal of such efforts is to build a steady stream of paying patients.

Despite its past tentativeness concerning jumping on the managed-care bandwagon, the institution's attitude has changed, Dr. Clough said.

"Our doctors have realized the need to do this," he said. "We've realized that the marketplace is changing and that we need to participate in something that shows our strength as a tertiary-care provider."

Since 1988, the Cleveland Clinic has signed about 50 managed-care contracts, including an agreement with Boston-based John Hancock Financial Services to serve as national healthcare provider for bone marrow, heart, kidney and liver transplants.

With physicians seemingly in the best position to manage healthcare costs, the "managed competition" approach supported by the Clinton administration actually may embrace the idea of physician-dominated systems.

But it's not something physicians have been anxious to embrace. Besides questioning their roles and responsibilities in creating a new healthcare delivery system, physicians have doubts about how quality would be maintained under reform. And the idea of "medicine as a business" inherently goes against a physician's nature to serve solely in the provider role.

Since Jan. 1, large and small medical groups have announced plans to form integrated systems in various California cities, including Sacramento, San Francisco and Stanford, and a number of tiny communities where medical groups have clinics, hospitals or offices.

Stanford (Calif.) University Medical Center is negotiating an affiliation agreement with Sequoia Redwood Medical Group, a group of 25 primary-care physicians in Redwood City, Calif.

The proposed affiliation would create a managed-care network offering healthcare purchasers a simplified referral program with access to both primary-care physicians and Stanford's multispecialty physicians.

For Stanford, it's the first time the teaching hospital has sought an affiliation with a primary-care group, said Peter Gregory, M.D., Stanford's medical director.

Dr. Gregory said Stanford wants to expand its services because its specialty physicians realize the importance primary care will play in creating an economical delivery system.

While most medical groups acknowledged the important role managed care already is playing, all predicted that coming reforms will make it more dominant. ■

RESPONSES OF MR. PROGER TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Question 1). Health related antitrust litigation didn't exist as a field twenty years ago. Everyone says there has been a litigation explosion. Please define the size of the explosion. What proportion of medical providers (hospitals, nurses and doctors) are at risk?

Response:

One needs to distinguish between the actual number of cases of antitrust litigation versus the "risk" of antitrust litigation. As discussed below, for a variety of reasons the antitrust laws generally were not applied to the health care industry until 1975. Given the size of the health care industry and the fact that economic forces as well as the perception of forthcoming health care reform are compelling a restructuring of the industry, it is not surprising that since 1975 there have been a number of antitrust actions filed in the industry. Thus, the risk of antitrust litigation is probably greater than in other more stable domestic industries. The key, however, is that the risk is not inherent to the nature of the health care industry and, as discussed below, may be managed.

Federal antitrust litigation is of two forms. One form is federal government enforcement. The Department of Justice may bring criminal or civil actions in an United States District Court. In recent years there has been only one criminal action, the so-called Tucson dentists case. The Department also may bring civil actions in federal court to obtain injunctive relief prohibiting the challenged conduct. The Federal Trade Commission also[1] may bring civil, but not criminal, actions in federal court and/or before an Administrative Law Judge. These actions likewise are for injunctive relief or "cease-and-desist" orders.

A second form is private litigation. Congress in passing the Clayton Act in 1914 recognized that enforcement by a private party could be an effective tool to prevent or halt anticompetitive conduct. A private party may obtain treble damages, injunctive relief and reasonable attorney fees plus costs. But to be a private treble damage plaintiff, a party must meet certain thresholds. That party must have been injured in its trade or business by reason of a violation of federal antitrust laws. And that injury must be "antitrust injury," in other words a type of injury from which the antitrust law seek to protect you. Thus, for example, a private party could not challenge a merger or joint venture because that party will be injured from the increased competition of that merger or joint venture. The antitrust laws do not protect a party from increased competition.

Private antitrust actions in the health care arena generally have been of only a few varieties. First, there have been actions by a provider excluded from a medical staff of a hospital or from a provider panel of a health plan. However, these actions are diminishing for two reasons. One, the Health Care Quality Improvements Act of 1986 grants a qualified immunity to physicians involved in "good faith" peer review. Two, these actions are the "dealer termination" cases of health care antitrust. That is, a

[1] The Department of Justice and Federal Trade Commission have a "treaty" under which matters are divided between the two agencies. Accordingly, a party generally will not be investigated or sued by both agencies on the same conduct.

medical staff or health plan should always win these cases unless they allow themselves to become an instrument of anticompetitive conduct by one group of providers against another provider or class of providers (e.g. podiatrists, midwives, osteopaths). Indeed, only a handful of plaintiffs have won such cases. Second, there have been a few actions by downstream providers (e.g. DME companies) against vertical integration by a hospital. While there have been three or four actions of this type, including the well-publicized Venice Hospital case, they constitute only a few actions and in most cases the hospitals have prevailed. Third, actions by one hospital against another hospital for predatory conduct (e.g. requiring a medical staff to admit a majority of patients to that hospital or requiring a health plan to contract with all of a multi-hospital system's hospitals). Again there only have been a few of these cases. And finally, fourth, there can be actions against mergers or joint ventures. There is only one reported case of an action in this category. Given the requirement of antitrust injury, discussed above, there are not likely to be many more of these.

It should be recognized that antitrust law is not the only legal theory upon which such actions may be based. Accordingly, these types of cases existed before the modern application of antitrust law to the health care industry in 1975 and still will exist even if there were no antitrust laws. For example, physicians have challenged medical staff denials, restrictions and expulsions under various theories of due process and contract law. Similarly, disadvantaged competitors have brought actions under theories of common law tort or unfair competition.

As noted above, the risk of antitrust litigation may be greater in the health care industry than any other United States industry. But what risk there is based on the dynamic changes ongoing in health care and the specific conduct by health care providers, not on any characteristic unique to the health care industry or health care providers. Particular types of behavior are unlawful regardless of the industry in which they take place. Accordingly, those most likely at risk are those in the health care industry who try to restrict consumer choice by unlawfully restricting or eliminating competition. Generally this would apply to those providers that are independent and competing. Providers who are employees, as a practical matter, are at little risk. Nurses and employed physicians, such as those employed by Kaiser or by a health plan, generally have little individual antitrust risk because they lack the economic incentives that cause others to enter into agreements or arrangements that restrict competition.

Question 1A) Is the risk of litigation increasing, and for which providers (hospital, nurses, doctors)?

Response: I believe that the risk is the same or even decreasing.

The risk may be decreasing for several independent reasons. First, and foremost, federal district courts since 1975 have become more familiar and comfortable with applying antitrust law to the health care industry. As a consequence, courts today are more likely to dismiss a frivolous health care antitrust claim then they were ten years ago. Plaintiffs, and plaintiff lawyers in particular, tend to adjust and avoid theories that are not likely to succeed. An example of this phenomenon is my sense that there has been a relative decline in the number of antitrust actions brought by physicians or other providers denied medical staff privileges.

Second, legal counsel for hospitals, physicians and other providers (and the providers themselves) have adjusted to the fact

that the antitrust laws apply to the health care industry and are more able to recognize antitrust issues and to counsel health care providers how to act without raising antitrust concerns. For example, previously hospitals that had antitrust medical staff problems often delegated medical staff decisions solely to the medical staff. Regretfully, sometimes that delegation was used by some providers to eliminate competition by other providers. Today hospital counsel advise their clients to ensure that the medical staff credentialing process is free of anticompetitive actions. As a consequence, overall the process has improved and hospitals that follow a few simple precautions have little or no antitrust risk.

Question 2). The Justice Department has recently published new guidelines to hospitals regarding joint ventures and mergers. Will the dissemination of this information impact the growth in litigation? Will it help the hospitals do what they need to do lawfully?

Response: The Department of Justice (the "Department") and Federal Trade Commission (the "Commission") jointly issued new Merger Guidelines on April 2, 1992. The first Merger Guidelines were promulgated solely by the Department of Justice in 1968. The Department replaced the 1968 Merger Guidelines in 1982 and revised slightly those Guidelines in 1984. The 1992 Merger Guidelines were issued jointly with the Federal Trade Commission.

The Merger Guidelines set forth the analytical discipline that the Department and Commission follow when reviewing mergers and joint ventures under the federal antitrust laws. The Guidelines first look to the structure of a market -- product and geographic -- to determine the concentration of that market. As a general rule, the fewer the firms in a market the greater the concern that the firms in the market will not behave competitively. If after the merger or joint venture there still are enough competitors that no one competitor could individually raise prices or restrict output (i.e. exercise market power) or the remaining competitors are too numerous for them to collude, then the analysis ends and the transaction is presumed lawful. If, on the other hand, after the proposed transaction concentration (and the increase in concentration) is high, then the analysis proceeds to analyze the competitive effects of the proposed transaction.

Thus, while the Merger Guideline's analytical discipline is the same in each transaction, the analysis is fact specific to each transaction. As a consequence, mergers that superficially appear similar often end up with different antitrust enforcement consequences. This apparent "inconsistency" troubles the industry and causes health care executives to express concern about making business decisions in an unpredictable legal environment. In fact, this lack of "predictability" is real, yet overstated. Health care executives are in no better or worse position than executives in other industries. Any legal standard based on the "effect on competition" inherently is less predictable than a bright line absolute standard. On the other hand, the flexibility of this legal standard benefits the industry and consumers by ensuring that lawful agreements are not prohibited by an inflexible, bright-line standard. Like the rest of United States industry, health care executives with competent legal advisors familiar with the Merger Guidelines and their application to various situations should be well able to know what is lawful and what is not.

The Merger Guidelines, in and of themselves, will not impact litigation regarding mergers and joint ventures. As noted in my response to Question 1, antitrust litigation is more likely to be private actions, rather than government actions. Due to standing requirements, private actions against mergers and joint ventures are far less frequent fewer than private actions against

exclusionary conduct actions (e.g. expulsion from medical staff or HMO network). Thus, private actions are not a major concern here.

However, as suggested in my prepared testimony, government and private actions could be minimized by specific antitrust guidelines for health care mergers and joint ventures and/or a voluntary process for agency (Department of Justice or Commission) review. Guidelines jointly issued by the Department of Justice and the Commission on health care mergers and joint ventures would reduce further the uncertainty of such transactions. More significantly, an agency review process (perhaps under those guidelines) that resulted in the parties being protected from criminal enforcement and private treble damage actions would be helpful. The review should be voluntary, timely and inexpensive. The burdens and costs of Hart-Scott-Rodino Premerger Notification should be avoided. The parties should provide the agencies certain limited information and require the agency that the reviews the transaction to respond within 90 days.

Finally, it should be noted that the National Cooperative Production Amendments of 1993 (HR 113) enacted into law on June 10, 1993 should help health care providers engaged in joint ventures for new services. The Act, which amended the National Cooperative Research Act of 1984, 15 U.S.C. § 4301 et seq., allows parties to file with the agencies their intention to joint venture a new product or service. Once filed the parties are immediately protected from treble damages. In addition, the transaction is analyzed under the rule of reason standard and not the more stringent per se standard. While this act is limited to new services and does not eliminate government enforcement or private suits for actual damages and/or injunctive relief, it will be useful to health care providers.

Question 3). What additional steps can the FTC and DoJ take to minimize litigation?

Response: As stated in my prior responses, the FTC and Department of Justice to minimize litigation could do the following:

1. Continue their education through advisory opinions, speeches and articles on the antitrust issues in the health care industry.

2. Publish joint guidelines on health care industry mergers and joint ventures.

3. Create a voluntary review process of health care industry mergers and joint ventures. That process should be timely (within 90 days) and not burdensome.

In addition to the above, Congress should consider when enacting health care reform requiring the FTC and Department of Justice jointly to publish guidelines in a timely fashion on the antitrust implications of implementing health care reform.

Question 4). On the eve of major health reform, do you see 'state action' and 'implied immunity' antitrust exemptions as the engine to slow if not eliminate most of today's major antitrust litigation?

Response: Attached hereto as Exhibit A to this Response is a copy of the Discussion Draft of a White Paper dated May 14, 1993 and entitled "Antitrust Implications of Health Care Reform" which was prepared by members, including myself, of the Section of Antitrust Law for the American Bar Association Working Group on Health Care Reform. (Please note that the White Paper has not been approved by the American Bar Association.) This White Paper at 13-16 discusses

the doctrines of implied repeal and state action and their applicability to health care reform.

Question 4A. Looking into your crystal ball, if accountable health partnerships or community care networks are created, what health-related antitrust activities will providers be liable for under antitrust?

Response: Attached hereto as Exhibit A to this Response is a copy of the Discussion Draft of a White Paper dated May 14, 1993 and entitled "Antitrust Implications of Health Care Reform" which was prepared by members, including myself, of the Section of Antitrust Law for the American Bar Association Working Group on Health Care Reform. (Please note that the White Paper has not been approved by the American Bar Association.) This White Paper at 8-13 discusses the application of antitrust law to accountable health partnerships (a/k/a/ community care networks).

Question 4B. For these remaining activities, would any be appropriate for exemption of antitrust law?

Response: Without knowing the specifics of health care reform, it is premature to identify any specific activities that should be exempted from antitrust law. Clearly to the extent that competition is an integral part of health care reform, the antitrust laws need to be preserved. Attached hereto as Exhibit A to this Response is a copy of the Discussion Draft of a White Paper dated May 14, 1993 and entitled "Antitrust Implications of Health Care Reform" which was prepared by members, including myself, of the Section of Antitrust Law for the American Bar Association Working Group on Health Care Reform (Please note that the White Paper has not been approved by the American Bar Association.) The White Paper after reviewing the likely antitrust issues arising from health care reform concludes at 14-15 that an express immunity is not needed. The White Paper states that "... the antitrust laws are a tool for protecting against excessive market power and collusion that could undermine the goals of health care reform. Under these circumstances, any broad antitrust exemption would be counterproductive." (footnote omitted).

To the extent that any part of the health care industry becomes pervasively regulated like a public utility then such regulated activities would not, and should not, be subject to antitrust laws. Once more detail is available on the specifics of health care reform, I would be pleased to respond to any questions regarding the need for an antitrust exemption.

EXHIBIT A

ANTITRUST IMPLICATIONS OF HEALTH CARE REFORM

Prepared as a Discussion Draft for the
American Bar Association
Working Group on Health Care Reform

DISCUSSION DRAFT
DO NOT QUOTE OR CITE FROM THIS DOCUMENT

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May 14, 1993

ANTITRUST IMPLICATIONS OF HEALTH CARE REFORM

TABLE OF CONTENTS

ANTITRUST IMPLICATIONS OF HEALTH CARE REFORM*

I. INTRODUCTION

A. Common Goals of Health Care Reform and Antitrust

Health care reform is crucial to the future economic well-being of our country. The success of health care reform depends on the ability to maintain quality of care, improve consumer access and choice, while reducing costs. To achieve these goals, health care reform contemplates the pooling of purchaser buying power in health care purchasing alliances ("Purchasing Alliances") that purchase from competing accountable health care plans ("AHPs").

The goals of the federal antitrust laws[1] and health care reform are the same: Both seek to enhance access to health care products and services while encouraging quality and efficiency. The antitrust laws have been applied by courts and federal enforcement agencies[2] to guard against aggregation or misuse of market power in the health care industry. Market power closes markets to new competition, reduces consumer choice, raises price and lowers quality as well as service. The antitrust laws also have prevented conduct that thwarts competition in the health care industry. As commentators have observed,[3] antitrust enforcement over the past fifteen years has opened markets to new, and often innovative, forms

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* THE VIEWS EXPRESSED IN THIS WHITE PAPER ARE SOLELY THOSE OF ITS AUTHORS, WHO HAVE BEEN EXTENSIVELY INVOLVED IN ANTITRUST AND HEALTH CARE MATTERS IN THEIR PRIVATE PRACTICES, AND DO NOT NECESSARILY REPRESENT THE VIEWS OF THE SECTION OF ANTITRUST LAW OR THE AMERICAN BAR ASSOCIATION. THIS REPORT HAS NOT BEEN REVIEWED OR APPROVED BY THE COUNCIL OF THE SECTION OF ANTITRUST LAW, THE HOUSE OF DELEGATES OR THE BOARD OF GOVERNORS OF THE AMERICAN BAR ASSOCIATION.

[1] The principal federal antitrust laws (the "antitrust laws") applicable to the health care industry are the Sherman Act, the Clayton Act, and the Federal Trade Commission Act. Section 1 of the Sherman Act, 15 U.S.C. § 1, prohibits contracts, combinations and conspiracies in restraint of trade. Section 2 of the Sherman Act, 15 U.S.C. § 2, prohibits monopolization, attempts to monopolize and conspiracies to monopolize. Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, prohibits "unfair methods of competition," as well as unfair or deceptive acts or practices. Section 7 of the Clayton Act, 15 U.S.C. § 18, prohibits mergers, joint ventures, consolidations, or acquisitions of stock or assets where the effect may be to substantially lessen competition or tend to create a monopoly. Most states have their own antitrust laws which often parallel the federal antitrust statutes. This paper will not discuss the applicability of state laws to the health care industry, although the analysis is substantially the same.

[2] The Federal Trade Commission (the "Commission") and the Antitrust Division of the Department of Justice (the "Justice Department") are responsible within the federal government for enforcing the antitrust laws. Additionally, private individuals and state attorneys general can file actions under the federal antitrust laws.

[3] See e.g., Statement of Howard M. Metzenbaum, Chairman, Senate Judiciary Committee Subcommittee On Antitrust, Monopolies & Business Rights before the Senate Finance Committee Subcommittee On Medicare & Long Term Care (May 7, 1993).

of health care, such as HMOs and PPOs. Much of what will be health care reform would not be possible without that prior antitrust enforcement.

The purpose of this paper is to provide an overview of how health care reform and the antitrust laws may interact. Fortunately, as discussed above and below, antitrust enforcement should not be a barrier to health care reform.[4] Antitrust enforcement, which promotes consumer choice and welfare while restricting anticompetitive conduct, will be vital to the implementation of health care reform. Still, a note of caution is appropriate. Antitrust analysis requires an understanding of the specific facts of the market and conduct being analyzed. As of the date of this paper, health care reform is more of an evolving concept, than a specific proposal. Thus, this paper is limited to identifying the basic antitrust issues that may arise from health care reform as it is now anticipated. Further analysis will be required once the Administration's health care reform proposal has been proposed.

B. A Brief History of Applying Antitrust Laws in the Health Care Industry

Antitrust laws have been applied generally to the health care industry only since the mid-1970s.[5] Prior to that time, the health care industry was effectively protected from federal antitrust enforcement because of a unique combination of immunities and defenses. Health care industry activities were said to be that of a "learned profession" or of a "non-profit organization" which were "regulated" by a state and often the "business of insurance". These labels generally precluded antitrust scrutiny. But in 1975 and 1976 the United States Supreme Court rejected the "learned professions" exemption,[6] the argument that health care activities had no substantial effect on interstate commerce[7] and limited the state action exemption to conduct mandated by the state.[8] In 1979, the Supreme Court made it clear that the exemption for the "business of insurance" did not extend to health care providers merely supplying services paid for by an insurance company.[9] Finally, in 1982 the Supreme Court held that the health care industry was fully subject to federal antitrust laws and was not entitled to any special immunity or relaxed antitrust standard.[10]

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[4] To the extent that antitrust enforcement is nevertheless perceived as a barrier to health care reform, the health care reform proposal itself should set the framework for antitrust enforcement in the health care industry. For specific examples of what the health care reform proposal may include to clarify any perceived uncertainty, see discussion following note 61, infra.

[5] Prior to the mid-1970s there was occasional antitrust enforcement. See e.g., United States v. Oregon State Medical Society, 343 U.S. 326 (1952); American Medical Association v. United States, 317 U.S. 519 (1943).

[6] Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975).

[7] Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738 (1976). See also Summit Health Ltd. v. Pinhas, 111 S.Ct. 1842 (1991).

[8] Cantor v. Detroit Edison, 428 U.S. 579 (1976).

[9] Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979).

[10] Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982).

Antitrust laws today prohibit conduct among competitors in the health care industry that seek to raise prices or deny consumers access to new forms of health care delivery systems.[11] For example, the Supreme Court has held per se unlawful a fee schedule arrangement among over 80 percent of the physicians in Phoenix where the physicians did not share economic risks and had not integrated their practices.[12] The Court's decision was consistent with the concern that the fee schedule eliminated price competition and that the high percentage of physicians involved deterred the development of other health plans which might have reduced costs further. The Court also has held unlawful under the antitrust laws provider or insurer efforts to exclude or collectively refuse to deal with third parties.[13]

Federal and state enforcement agencies and private parties also have looked to the antitrust laws to ensure that markets were open to alternative forms of health care delivery systems that wished to compete in the market with traditional fee-for-service arrangements. For example, the Commission and the Justice Department have successfully challenged (1) efforts by hospitals and physicians to prevent physicians affiliated with HMOs from being granted staff privileges at local hospitals;[14] (2) collective actions to prevent the entry of new competitors,[15] such as a multispecialty clinic with an innovative pricing system, into a local health care market;[16] (3) concerted efforts by physicians to deny alternative health care providers, such as podiatrists and nurse-midwives, access to hospital staff privileges;[17] (4) joint efforts by local medical societies or groups of physicians to thwart the development of PPOs or other forms of managed care arrangements;[18] (5) joint efforts by hospitals or physician associations to

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[11] These types of collaborative conduct between competitors without integrative efficiencies are generally per se illegal, which means that because of repeated experience with the practice's adverse effect on competition, the courts conclusively presume such conduct to be unreasonable.

[12] Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982).

[13] E.g., F.T.C. v. Indiana Federation of Dentists, 476 U.S. 447 (1986); Barry v. St. Paul Fire & Marine Ins. Co., 438 U.S. 531 (1978).

[14] United States v. Halifax Hosp. Medical Center, 1981-1 Trade Cas. (CCH) ¶ 64,151 (M.D. Fla. 1981)(consent decree); Eugene M. Addison, M.D., 111 F.T.C. 339 (1988)(consent order); Forbes Health Sys. Medical Staff, 94 F.T.C. 1042 (1979)(consent order).

[15] Dirian M. Seropian, M.D., Nos. C-3344; 3345 (F.T.C. June 13, 1991) (consent order prohibiting medical staff and chief of staff from precluding physicians of competing Cleveland Clinic from staff privileges); Medical Staff of Dickinson County Mem. Hosp., No. C-3259 (F.T.C. July 17, 1989) (consent order prohibiting medical staff and medical societies from attempting to prevent hospital from building multispecialty medical office that would compete against them).

[16] Medical Staff of John C. Lincoln Hosp. & Health Center, 106 F.T.C. 291 (1985)(consent order).

[17] Health Care Mgt. Corp., 107 F.T.C. 285 (1985)(consent order)(podiatrists); Medical Staff of Mem. Medical Center, 110 F.T.C. 541 (1988)(consent order)(nurse midwives).

[18] Indiana Fed'n of Dentists, 476 U.S. 447 (1986); American Medical Ass'n v. United States, 317 U.S. 519 (1943).

limit truthful advertising or price advertising;[19] and (6) joint arrangements by providers to boycott federal or state health programs unless reimbursement fees were raised.[20] It is this enforcement that has paved the way for health care reform and the more innovative delivery systems contemplated by health care reform.

Federal antitrust enforcement agencies also have reviewed hospital mergers. Most hospital mergers have been viewed as unlikely to create sufficient market power for the merged hospital either to raise prices or exclude competition and as a consequence have not been challenged.[21] Nevertheless, the hospital industry has expressed concern that the possibility of an expensive and time consuming challenge deters some "close call" mergers that would benefit consumers. While that concern is real and some transactions may not have taken place, overall antitrust enforcement has not deterred hospital mergers and in fact, the hospital industry has seen a recent wave of mergers.[22]

Neither the Commission nor the Justice Department has challenged a joint venture among hospitals.[23] Federal enforcement officials have stated that the antitrust laws should not prohibit providers from jointly purchasing or sharing expensive equipment or new medical technology, particularly where efficiencies can be gained from such arrangements, so long as the joint arrangements would not confer market power on the participants (such that the joint venturers could raise prices or exclude competition).[24] On the other hand, so-called "joint ventures" that simply eliminate competition for existing services raise antitrust concerns.

Although the concept of applying antitrust laws to the health care industry was somewhat novel fifteen years ago, courts have become more sophisticated in applying antitrust law to the health care industry. As a consequence, today there is a body of legal precedent analyzing antitrust implications of

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[19] American Medical Ass'n v. F.T.C., 638 F.2d 443 (2d Cir. 1980), aff'd by equally divided Court, 452 U.S. 960 (1982).

[20] Michigan State Medical Soc'y, 101 F.T.C. 191 (1983).

[21] From 1987-1991, approximately 229 hospital mergers occurred. The enforcement agencies opened formal investigations into 27, and challenged five. Statement of Charles A. James, Acting Assistant Attorney General, Antitrust Division, Department of Justice before the Joint Economic Committee of the House-Senate Subcommittee on Investment, Jobs and Prices (June 24, 1992).

[22] See "Mergers thrive despite wailing about adversity," Modern Healthcare (Oct. 12, 1992); "Collaboration deserves a clear map, but not an antitrust pass," Modern Healthcare (Oct. 19, 1992).

[23] "The Role of Antitrust in Improving and Reforming the Health Care System," remarks of Kevin J. Arquit, Director, Bureau of Competition, Federal Trade Commission, before the American Bar Association (Oct. 15, 1992)("There is not a single instance of federal government challenge of a hospital joint venture.") (emphasis in original).

[24] "Federal Trade Commission Antitrust Enforcement in the Health Care and Hospital Industries," remarks of Deborah K. Owen, Commissioner, Federal Trade Commission, before the American Osteopathic Hospital Association (Oct. 11, 1992); "The Myths and Realities of Antitrust Enforcement in the Hospital Industry," remarks of Mark J. Horoschak, Assistant Director, Bureau of Competition, Federal Trade Commission, before the National Council of Community Hospitals (Nov. 13, 1992).

various practices in the health care industry. This precedent suggests that antitrust laws should not be a barrier to most joint or collaborative efforts in health care reform. Unless Congress provides otherwise through express or implied repeal of antitrust laws or allows state action initiatives which have the same effect, antitrust laws will continue to promote and protect the new methods of delivery contemplated by health care reform.

II. ANTITRUST ISSUES RAISED BY HEALTH CARE REFORM

Health care reform contemplates the aggregation of purchasing power through Purchasing Alliances on the purchaser side and the formation of AHPs on the provider side. The countervailing power resulting from Purchasing Alliances would help reduce costs by assuring that efficiencies created by AHPs are passed back to the consumer. AHPs will integrate health care financing with services to create efficiencies in the financing and providing of health care services. As discussed below, neither presents a significant antitrust risk, particularly if consumers have a choice as to the Purchasing Alliances[25] in which they may participate and Purchasing Alliances have competing AHPs from which they may select.

A. Purchasing Alliances

1. Antitrust Considerations in Group Purchasing

As a general rule, the mere pooling of purchasing power is not unlawful under antitrust laws. As one Federal Trade Commission official noted, "Cooperative buying arrangements seem to be the one area of collaborative activity in which the potential for cost-reducing efficiencies is high and the potential for anticompetitive effects is low."[26] Similarly, the Supreme Court has held that joint purchasing arrangements are generally "designed to increase economic efficiency and render markets more, rather than less, competitive." They are not, according to the Court, "a form of concerted activity

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[25] We have assumed for purposes of this paper that Purchasing Alliances will be private entities. If, however, they are governmental entities, it is unlikely that they would be subject to the antitrust laws. As government entities they would be subject to administrative procedure and due process requirements which are beyond the scope of this paper. We also have assumed for purposes of this paper that Purchasing Alliances will be "purchasers" and not "regulators." If the Purchasing Alliances become regulators determining which AHPs or providers may offer which services at which prescribed prices, then significant other antitrust issues would be raised. Similar issues were raised in the regulatory system created under the National Health Planning and Resources Development Act of 1974, Public Law 93-641 (1974)(now repealed). See footnote 51, infra. Those issues also are outside the scope of this paper. Of course, if requested we would be available to help identify and analyze those issues.

[26] "Group Buying and Antitrust," Kevin J. Arquit, Director, Bureau of Competition, Federal Trade Commission before the American Bar Association, Section of Antitrust Law Health Care Committee, 10 (April 2, 1992). The federal enforcement agencies have not been a roadblock to joint purchasing arrangements and have expressly approved multipayor health care purchasing plans. See e.g., F.T.C. Staff Advisory Opinion Letter from Arthur N. Lerner to Michael L. Denger regarding Private Healthcare Systems, Ltd. (Sept. 24, 1985) (PPO formed by group of health insurers).

characteristically likely to result in predominantly anticompetitive effects."[27] Consequently, joint purchasing arrangements are usually subject to a rule of reason analysis. Typically, joint purchasing arrangements violate antitrust laws only when there is no integration by the purchasers to achieve efficiencies or there is the aggregation of so much purchasing power that prices will be forced below a competitive level and ultimately output by sellers may be reduced to the detriment of consumers.

A group purchasing arrangement should involve some integration by the purchasers which results in efficiencies to both the purchasers and the sellers of the products or services. Most purchasing groups coordinate their search for, evaluation of, and negotiations with suppliers and thereby realize substantial cost savings which they could not have obtained without coordination. Similarly, suppliers realize efficiencies by obtaining purchase commitments, which typically yield economies of scale and reduce business risk.[28] Accordingly, cases involving joint purchasing in the health care industry generally reflect a lack of judicial hostility to group purchasing arrangements[29] or large purchasers.[30]

Few cases have found joint purchasing arrangements unlawful. Virtually every one of those has involved a naked price fixing conspiracy whereby the purchasers did not integrate any purchasing functions to achieve efficiencies.[31] Instead of purchasing jointly or offering sellers a guaranteed level of sales from purchasers as a group, those purchasers merely agreed together to force lower prices for a particular service or product usually by threatening to boycott the providers unless they reduced their prices.[32] Rather than encouraging rational, economic decision-making by sellers, those purchasers sought to coerce sellers to offer lower prices, regardless of the long-term consequences of such coercive activities.

Thus, the principal antitrust concern with large joint purchasing arrangements is that they may create excessive purchasing power, sometimes referred to as monopsony power, which can force prices too low (e.g., below a competitive level) and ultimately result in less services (e.g., reduced output) which injures consumers by reducing their choices. However, monopsony power is unlikely to occur where there are several competing Purchasing Alliances.[33]

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[27] Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co., 472 U.S. 284, 295 (1985).

[28] Arquit, supra note 26, at 2-3.

[29] See e.g., White & White, Inc. v. American Hospital Supply Corp., 723 F.2d 495 (6th Cir. 1983); Webster County Memorial Hospital, Inc. v. United Mine Workers of America Welfare & Retirement Fund, 536 F.2d 419 (D.C. Cir. 1976).

[30] See e.g., Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc., 784 F.2d 1325 (7th Cir. 1986); Kartell v. Blue Shield of Massachusetts, Inc., 749 F.2d 922 (1st Cir. 1984).

[31] See e.g., Mandeville Island Farms, Inc. v. American Crystal Sugar Co., 334 U.S. 219 (1948); Vogel v. American Society of Appraisers, 744 F.2d 598, 601 (7th Cir. 1984).

[32] Arquit, supra note 26, at 7-8.

[33] See generally, Jacobson & Dorman, "Joint Purchasing, Monopsony & Antitrust," 36 Antitrust Bulletin 1, 4 (1991).

The Justice Department has used an informal benchmark of 35% for the group's aggregate share of all purchases in the market as the point below which the group buying arrangement is unlikely to have an anticompetitive effect.[34] Joint purchasing arrangements which exceed this safe-harbor, however, are not necessarily unlawful.[35]

2. Health Care Reform

The aggregation of the purchasing power of individuals and employees principally of small employers through the formation of Purchasing Alliances is unlikely to raise serious antitrust questions, particularly if consumers can choose from several Purchasing Alliances. Indeed, the purchasing power of Purchasing Alliances that is contemplated by health care reform is essential to one of its principal goals -- cost containment -- and preferable to price controls.[36] While price controls may have short-term benefits of reducing price increases, history shows that such controls will have long-term dislocative effects of limiting supply and only delaying ultimately larger price increases.

Under health care reform Purchasing Alliances may perform a variety of roles including the negotiation, selection and certification of AHPs or their role may be more limited. To the extent that Purchasing Alliances merely provide information to their members with respect to various AHPs and do not act as a joint purchasing agent that performs other roles, they will not present an antitrust concern. Even if they act as joint purchasing agents on behalf of small employers and others, Purchasing Alliances

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[34] This safe harbor has become known as the "35/20 rule" from the business review letters from which it was developed. Under this rule, the Justice Department does not challenge buyer cooperatives as long as the members collectively account for less than 35% of purchases in the market and the cost of the input represents less than 20% of the price of the final product offered for sale by the purchasers. See e.g., FRA Shippers Association, BRL No. 88-7 (June 17, 1988); North American Shippers Association, BRL No. 88-2 (March 16, 1988); National Telecommunications Network, BRL No. 86-10 (June 17, 1986). The Justice Department chose 35% because that was the point under its Merger Guidelines at that time that a leading firm could unilaterally exercise market power. "The Antitrust Division's Approach to Shippers' Associations," Charles F. Rule, Deputy Assistant Attorney General, Department of Justice (Oct. 21, 1985). It should also be noted that at 35% there should be at least three competing purchasing arrangements in the market.

[35] Few, if any, cases have found joint purchasing arrangements involving less than 60% of the market to be unlawful. See e.g., Mandeville Island Farms, Inc. v. American Crystal Sugar Co., 334 U.S. 219, 222-23 (1948) (buyers accounted for all purchases); United States v. Women's Sportswear Mfrs. Ass'n, 336 U.S. 460, 462 (1949) (buyers accounted for 80%); National Macaroni Mfg. Ass'n v. F.T.C., 345 F.2d 421, 427 (7th Cir. 1965) (buyers accounted for 70%); Live Poultry Dealers Protective Ass'n v. United States, 4 F.2d 840, 841 (2d Cir. 1924) (buyers accounted for more than 50%).

[36] Of all possible antitrust violations, the most egregious is price fixing which denies consumers the benefits of a market price determined by the normal marketplace functioning of supply and demand. It is for this reason that temporary price controls, rate regulation or even in some circumstances global budgets are viewed as an anathema to the competitive model which seeks to obtain the best products and services at the lowest possible prices. Price controls of any sort generally stifle innovation, decrease output and require an enormous bureaucracy to enforce.

would be unlikely to present an antitrust risk under current law if they account for one-third or less of the health insurance purchases in that area.[37]

In sum, antitrust concerns may be minimized by requiring several Purchasing Alliances in each service area. Moreover, if there are competing Purchasing Alliances, consumers would benefit by having a choice of which Purchasing Alliance to join. Such choice would also encourage the Purchasing Alliances to be efficient in controlling costs and vigilant in controlling costs of the AHPs with which they contract.

B. Accountable Health Plans

1. Antitrust Considerations in Provider Collaborations

Health care reform envisions the formation of AHPs which would contract with Purchasing Alliances to provide health care services to the individuals enrolled in that Purchasing Alliance. The actual health care services would be delivered by providers who are employed by or contract with a network formed within the AHP. The AHP would manage the delivery of health care services, including selection and integration of providers, utilization review, quality assurance, claims processing and network maintenance. Thus, the formation of AHPs as well as their provider networks necessarily contemplates collaboration among health care insurers and providers.[38] Provider collaboration would take various forms including horizontal integration through merger, joint venture or contract among physicians or among hospitals as well as nonhorizontal integration among physicians and hospitals or payors.

Collaboration may be procompetitive to the extent it achieves efficiencies or introduces new or cost-effective products into the marketplace when individual entities within a market cannot do so alone. Collaboration is permissible under the antitrust laws as long as (1) it does not involve the abusive exercise of market or monopoly power, which may have the effect of increasing prices or limiting output; (2) it

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[37] It is not clear under health care reform by whom and how AHPs or providers in AHPs will be selected or if Purchasing Alliances will enter into exclusive arrangements with AHPs. The selection of a particular AHP or providers in that AHP by a Purchasing Alliance that is without market power is not likely to violate the antitrust laws. See e.g., White & White v. American Hospital Supply Corp., 540 F. Supp. 951, 1033-1036 (W.D. Mich. 1982), aff'd, 723 F.2d 495 (6th Cir. 1983). Nevertheless, in selecting AHPs and providers the Purchasing Alliance should use objective criteria such as location, specialty, utilization review, malpractice experience and coverage, prices, and existing patients. In addition, an exclusive arrangement between a Purchasing Alliance and an AHP in the market where there are fewer than three Purchasing Alliances should be avoided. Moreover, the term of the contract between a Purchasing Alliance and an AHP should be limited. Terms beyond two or three years, particularly where there are few Purchasing Alliances or already existing exclusive contracts, restrict competition by perpetuating vertical foreclosure. If such contracts are to be of a term beyond two or three years, that contract should result in additional efficiencies created by the additional term. For example, it may be appropriate to have longer term contracts whereby the parties jointly invest in new technology or new services that require long-term payback.

[38] Once again for purposes of this paper we have assumed certain functions that will be performed by AHPs and provider networks. For the most part, we have also assumed that collaboration among providers will entail economic integration which is a critical factor in the antitrust analysis.

involves sufficient integration of provider resources and operations and the sharing of the financial risk of the venture to ensure its efficiency;[39] and (3) it does not entail unreasonably exclusionary arrangements or boycotts.

To the extent the collaboration integrates competing providers or insurers, it reduces the alternatives from which consumers may choose. But it also creates efficiencies. The key is to assure that, after the collaborative venture is formed, it will not have enough market power to retain the higher profits resulting from its efficiencies, but instead will be forced as a result of competition to pass them on to consumers in the form of reduced prices.[40]

2. Economic Integration Creating Efficiencies

Integration among providers can include substantial capital or financial contributions, common management, billing, marketing, claims administration, quality assurance or utilization review. However, the key to "integration" in this context is the assumption by providers of a substantial risk of the venture's economic success or failure, which usually results from unexpectedly high utilization or costs in the provision of a venture's health care services.[41] Capitation systems have been found to incorporate this type of risk-sharing.[42] Substantial financial and operational integration, including risk-sharing, is often inherent in capitation arrangements such as HMOs and is likely to be found in the kinds of provider networks and AHPs contemplated by health care reform proposals. As discussed, the key is that there be significant efficiencies created by the provider collaboration. If there are efficiencies and if there is competition between AHPs to force the efficiencies to be returned to consumers, then health care reform will produce cost savings.

3. Market Power

Provider collaboration in connection with the formation and operation of AHPs poses an anticompetitive threat to consumers if after the collaboration the providers have sufficient market power to increase prices or limit output to consumers. The vast majority of provider collaborations lack sufficient market power to raise serious antitrust problems. As a general rule, collaborative activities

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[39] The existence of meaningful integration and risk-sharing is essential to the venture's integrity from an antitrust standpoint. If the venture is nothing more than an affiliation of unintegrated competitors which is a cartel whose joint pricing will be viewed as price-fixing. Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982). Cartels restrict competition to benefit members, not consumers. Thus, an affiliation of competitors without integration (i.e. efficiencies) does not create cost savings. Rather, more likely, it restricts or eliminates consumer choice and increases costs to consumers.

[40] Collaboration by and between competing providers that restricts competition and that has no integrative efficiencies is per se unlawful. If the collaboration has integrative efficiencies, it will be judged under the rule of reason. Under the rule of reason, the loss in consumer welfare due to the anticompetitive restrictions is balanced against the gain in consumer welfare due to the efficiencies. See F.T.C. v. Indiana Fed'n. of Dentists, 476 U.S. 447 (1986); Massachusetts Bd. of Registration in Optometry, 110 F.T.C. 549 (1988).

[41] See Preferred Physicians, Inc., 110 F.T.C. 157 (1988).

[42] Hassan v. Independent Practice Associates, P.C., 698 F. Supp. 679 (E.D. Mich. 1988).

among providers with less than a third of the market do not raise serious antitrust problems.[43] Therefore, as a practical matter, antitrust laws would allow the formation of AHPs as long as there are several competing AHPs in any given market.

If only one AHP is formed in a market, however, consumers would not have sufficient choices to protect themselves from the AHP's abuse of its dominant position. Providers in the only AHP in the market would have the potential to aggregate excessive market power or abuse the market power conferred upon them by charging higher prices, refusing to lower prices or excluding new entrants. By the same token, if only one provider network is formed to contract with the AHPs, it may have market power and be tempted to refuse to contract on terms likely to lower costs to consumers. The more AHPs and networks that are formed, the more choices for consumers, the less antitrust concern and the more likely health care reform will produce cost savings.

4. Ancillary Restraints

Restrictions which are reasonably necessary or "ancillary" to integrated joint ventures are usually permissible under the antitrust laws.[44] Thus, joint pricing by providers within an integrated network or an AHP does not violate the antitrust laws. In addition, to the extent that providers share, consolidate, or allocate resources within the network to offer comprehensive or better-quality health care coverage, such decisions should also be permissible. For example, network hospitals may form a joint venture for the provision of specialty care or may share in the development, purchase or use of expensive facilities, equipment or technologies. Such arrangements are lawful under the antitrust laws as long as they create efficiencies and do not result in market power.[45]

Even where pricing or market allocation decisions by an integrated, risk-sharing joint venture (such as a provider network or an AHP) are permissible, if their joint decisions within that network or

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[43] Hyde v. Jefferson Parish Hospital District, 466 U.S. 2 (1984), suggests that a market share of less than 30% does not constitute "market power" for purposes of Section 1 of the Sherman Act. Although the Antitrust Division of the U.S. Department of Justice had established a 35% market share "safe harbor" for health care joint ventures such as PPOs (Remarks of Charles F. Rule, then Assistant Attorney General, Antitrust Division, U.S. Department of Justice, "Antitrust in the Health Care Field: Distinguishing Resistance from Adaptation" (March 11, 1988)), this harbor was modified in favor of a case-by-case analysis of the particular specialties of the joint venture (Remarks of James F. Rill, then Assistant Attorney General, Antitrust Division, U.S. Department of Justice, "Antitrust Enforcement Policy and the Treatment of Horizontal Restraints: Lessons for the Health Care Industry" (February 15, 1991)). Nevertheless, these figures continue to represent rough guidelines for the measurement of market power.

[44] See Rothery Storage & Van Co. v. Atlas Van Lines, Inc., 792 F.2d 210 (D.C. Cir. 1986), cert. denied, 479 U.S. 1033 (1987).

[45] In the absence of such integration, however, joint pricing or market allocation agreements among providers are likely to be per se unlawful under current law because they yield higher prices and fewer choices for consumers. Thus, for example, if competing providers negotiate jointly with AHPs in forming their networks, or if a group of competing AHPs collectively set prices to Purchasing Alliances, such conduct would be unlawful as price-fixing. By the same token, if competing providers divide markets, for example, with one provider doing all OB/GYN services and the other performing all cardiology services where both entities had previously been in both markets, the arrangement would likely be unlawful. See Palmer v. BRG of Georgia, Inc., 111 S. Ct. 401 (1990); U.S. v. Topco Associates, 405 U.S. 596 (1972).

AHP spill over to collusion on prices for services they offer outside the framework of the network or AHP, such "spillover collusion" would violate the antitrust laws.

5. Inclusiveness/Exclusive Dealing

a. Provider Participation. Providers have substantial leeway under the antitrust laws to decide whom to include within a provider network or AHP. Unless these ventures have excessive market power, the exclusion of specific providers from them is not likely to raise antitrust concerns. For example, if there are three or four AHPs in a given market, the exclusion of a provider from one of them generally would not be a problem under the antitrust laws, since such providers could contract with another AHP.

Antitrust issues may arise, however, if the exclusion of health care providers has substantial potential to raise prices. For example, if providers themselves determine which providers are admitted to AHPs, there might be a potential for excluding certain types or classes of providers, such as podiatrists, chiropractors, nurse-midwifes or psychologists, who have been battling certain elements of the medical establishment for access to consumers. Such exclusions may be actionable under the antitrust laws, especially if the excluded providers have no reasonable alternative AHPs with which to affiliate.[46] If health care reform establishes specific guidelines on provider participation, then it is less likely that there will be antitrust concerns in this area.

b. Exclusive Dealing. Exclusive arrangements between providers and their networks or between provider networks and AHPs are likely to be part of health care reform. Exclusive arrangements are often procompetitive and are, therefore, ordinarily lawful under the antitrust laws. For example, an exclusive contract between a hospital and one of several competing provider groups that ensures continuity of coverage, improves efficiency and utilization of facilities and resources, or increases the volume of a particular procedure performed at a given institution, thus decreasing costs and increasing the quality of care at the institution, is not unlawful. The drive by insurers to create "Centers of Excellence" (i.e., designated institutions for the performance of particular specialties or procedures) exemplifies the recognized advantages of exclusive arrangements. Similarly, an exclusive arrangement between one of several tertiary care facilities in a given market and an AHP with an insubstantial percentage of the subscribers in that market (less than 30% to 35%) will not unreasonably foreclose other tertiary care facilities from participating in the market or preclude competition among the AHPs.

Only if exclusive arrangements involve the exercise of substantial market power in either party's market (e.g., providers with high market shares) are they likely to be found unreasonably exclusionary and thus anticompetitive.[47] The amount that each market (i.e. the percentage of health care served by that AHP and the percentage of those provider services served by those providers) will be foreclosed needs to be determined. As discussed, if either percentage of foreclosure exceeds 35 percent, then exclusivity is best avoided.

The term of the contract between the providers and the AHP also is important. Long term contracts that restrict competition should be avoided. Obviously, the shorter the term the shorter the restriction on competition. Generally, the term of an exclusive contract should be three years or less.

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[46] E.g., Wilk v. American Medical Association, 719 F.2d 207 (7th Cir. 1983), cert. denied, 467 U.S. 1210 (1984), on remand, 671 F. Supp. 1465 (N.D. Ill. 1987).

[47] See Hyde v. Jefferson Parish Hospital District, 466 U.S. 2 (1984).

If the participation of certain essential providers (e.g., with unique specialties) or hospitals (e.g., a teaching hospital) is critical to the ability of all AHPs to compete effectively, then one AHP's exclusive arrangements with these providers or hospitals may create market power and be anticompetitive. For example, all AHPs will need anesthesiologists. If one AHP contracts exclusively with the only anesthesiology group in a market, then the other AHPs are at a significant competitive disadvantage. Exclusivity provisions in a market with only a few AHPs could also foreclose competitors of the providers with exclusive relationships from access to participation in the AHPs that would be necessary for the excluded providers to compete. Under these circumstances the safest approach from an antitrust perspective would be to not restrict providers from participating in alternative AHPs.

c. Boycotts. Boycotts by providers occurred in response to the early evolution of HMOs, as well as to thwart attempts by allied health care practitioners to obtain access to facilities, particularly tertiary care facilities. In the context of health care reform, examples of unlawful boycotts could include efforts among providers or their networks to refuse to deal with particular AHPs if the terms of such plans were "unacceptable" to them; decisions among provider networks not to include certain categories of providers; or decisions among AHPs not to deal with certain provider networks. Boycotts by competing providers to exclude new entrants, new forms of services, or low-cost providers from the network or AHP would be unlawful.[48]

6. Provider Mergers and Consolidations. Health care reform also is likely to encourage mergers and consolidations. The antitrust laws prohibit only those mergers, consolidations or acquisitions that have a tendency to create a monopoly or lessen competition substantially in a given market. Whether a merger is unlawful depends upon a broad array of competitive factors, including the number of providers in the market; the degree to which the merger will increase the concentration of providers and reduce consumer choice; the ease by which new providers may enter the market; efficiencies created by the merger; and whether the merger will prevent a failing firm from leaving the market. As a practical matter, most mergers of health care providers in metropolitan areas are not unlawful under this analysis.

The antitrust laws are sufficiently flexible to permit consideration of efficiencies arising from the elimination of duplicative facilities or excess capacity, although those factors are not sufficient, in and of themselves, to justify a merger the result of which would be to create excessive market power. Accordingly, mergers or joint ventures may raise questions under the antitrust laws if, as a result, there are not sufficient hospitals or providers remaining to support the formation of competing AHPs. In practice, however, the antitrust enforcement agencies have challenged few mergers, and the cases in which courts have invalidated mergers are few.[49]

7. Integration of Providers and Insurers.

The vertical integration of providers and insurers that is contemplated by health care reform can generate substantial efficiencies and improve quality of care in the delivery of health care. At present, there is a variety of existing arrangements involving vertical integration which are permissible under the antitrust laws, including, for example, physician-hospital organizations, hospital arrangements with

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[48] See F.T.C. v. Indiana Federation of Dentists, 476 U.S. 447 (1986).

[49] See F.T.C. v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991); U.S. v. Rockford Memorial Corp., 898 F.2d 1278 (7th Cir.), cert. denied, 111 S. Ct. 295 (1990); Hospital Corp. of America v. F.T.C., 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987); Adventist Health Systems/West, Docket No. 9234, 1992 F.T.C. Lexis 297 (Dec. 9, 1992).

ancillary providers (such as home health care or durable medical equipment providers), and community care networks where providers at different levels in the delivery system coordinate the provision of care. These arrangements are typically permissible under the antitrust laws as long as they do not involve the exercise of excessive market power, for example, by leveraging power in one market unfairly to exclude competing providers in another market, thus raising prices or limiting consumer choice.

Managed care today already is integrating in many market providers and insurers. As discussed, this managed care integration generally raises few antitrust concerns. The key, as discussed with respect to Purchasing Alliances contracting with AHPs and AHPs in turn contracting with providers, is to ensure that after the insurer/provider integration, there still are enough insurers and providers to form other AHPs.

III. IMMUNITIES AND EXEMPTIONS

A. Overview of Possible Immunities

Competition is expected to be an integral factor in health care reform. As discussed, the antitrust laws are not a barrier to health care reform. Moreover, in a reformed health care system, the antitrust laws can be an effective tool in maintaining the proper balance between, and the efficient operation of, the large integrated networks of providers and large alliances of purchasers contemplated by health care reform. Thus, a blanket antitrust exemption is neither necessary nor desirable to the overall purpose or implementation of health care reform..

The antitrust laws can be displaced by Congress through express or implied exemption from the antitrust laws ("express or implied repeal") or by individual states that choose to regulate in areas where competition would otherwise be required ("state action"). The elements and requirements for the various methods of modifying the application of the antitrust laws, as well as the potential loophole that may remain under a health care reform package for states to enact legislation at the state level that would thwart achievement of the goals of a health care reform package, are discussed below.

B. Express Exemptions and Implied Immunities

1. Implied Repeal

When Congress passes legislation (e.g., health care reform) that is inconsistent with laws previously enacted (e.g., the antitrust laws), the pre-existing statute is said to be repealed to the extent necessary to effectuate the new statute.[30] This occurs not only when Congress includes language in the subsequent legislation explicitly repealing the earlier legislation or some portions of it, but also when Congress passes inconsistent legislation without acknowledging the inconsistency or expressing its view as to how the two pieces of legislation are to co-exist. In such cases, the two statutes, their histories, purposes, and methods are examined to ascertain Congressional intent regarding operation of the two statutory schemes. A subsequent statute can be found impliedly to repeal a preceding statute if the two

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[30] Silver v. New York Stock Exch., 373 U.S. 341 (1963); United States v. National Ass'n of Sec. Dealers, 422 U.S. 694 (1975).

statutory schemes are "clearly repugnant" so that operation of one makes impossible operation of the other.[51]

Accordingly, if as enacted, health care reform requires conduct that ordinarily raises antitrust concern, then that conduct arguably would be immune if and to the extent that the conduct was necessary to effectuate health care reform. For example, health care reform may require the formation of provider networks to contract exclusively with a particular insurance company. The doctrine of implied repeal would immunize that exclusive contract. But the doctrine would not immunize anticompetitive conduct within that network, that was outside the scope of health care reform. If one group or type of providers used their collective power to exclude another group of providers, that exclusionary conduct not called for by health care reform would not be immune.

As the above illustration suggests, the doctrine of implied repeal strikes an appropriate balance. While it will immunize conduct required by health care reform, it will not immunize conduct not so required. Merely because health care reform requires the formation and operation of a network does not mean that network providers are free to engage in any conduct. Conduct not specifically required by health care reform that harms consumer welfare still would be subject to antitrust laws.

2. Express Immunity

Health care reform and the antitrust laws share common goals in that both seek to preserve quality of care and consumer choice and reduce costs. Far from being "clearly repugnant" to health care reform, the antitrust laws are a tool for protecting against excessive market power and collusion that could

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[51] The Supreme Court considered the possibility of an implied repeal of the antitrust laws by the National Health Planning and Resources Development Act of 1974, Public Law 93-641 (1974) (now repealed), which established a regulatory framework for the development of health facilities. The Act provided for a network of organizations and officials to study health care needs and permit new construction and development only where there was a determined "need." The regulatory system provided not only for mandatory "certificates of need" (if states opted into the federal health planning system), but also called for voluntary action by private providers to engage in private action consistent with the "needs" determined for the area. While the health planning laws were grounded in a philosophy antithetical to the antitrust laws (looking to regulation rather than competition for containing health care costs) and reflected a Congressional belief that competition was irrelevant in the health care industry, the health planning laws were held not to repeal impliedly the antitrust laws. Because the health planning laws stated that providers "may" engage in certain conduct, but did not require parties to engage in that conduct, the Supreme Court found that they were not "clearly repugnant" to provide a blanket implied repeal. Thus, even if private cooperative conduct were encouraged by the health planning law, and were engaged in for that purpose, there may be no antitrust immunity. However, specific requirements of a health planning or other law might be sufficient impliedly to repeal the antitrust law. National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City, 452 U.S. 378 (1981). The Court left open the possibility that specific conduct required by federal or state health planning laws would be immune from antitrust scrutiny but found that conduct taken to further the "goals of" the health planning laws would not ipso facto be immune from the antitrust laws.

undermine the goals of health care reform. Under these circumstances, any broad express antitrust exemption would be counterproductive.[52]

Nevertheless, if some specific area is deemed inappropriate for antitrust scrutiny, a narrowly drawn express exemption may be proposed.[53] However, to the extent that conditions are believed necessary to justify an antitrust exemption for particular conduct, other legislative safeguards would be necessary to ensure that the exemption did not result in higher prices, reduced output, barriers to entry or innovation, or other exclusionary conduct that would frustrate the purpose of the legislation.[54]

C. State Action Immunity

In our dual system of government, antitrust exemptions may also result from state regulation inconsistent with federal antitrust laws.[55] Such "state action" immunity flows from the concept that states may determine that in particular areas a system other than competition is desirable. Unlike Congress, states cannot simply mandate that federal antitrust laws do not apply to particular conduct. To create an antitrust exemption, states must supplant competition with a system of state regulation

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[52] There are several proposals currently pending in Congress for various antitrust exemptions. These proposals for the most part are premised on arguments that the antitrust laws significantly chill conduct that could be helpful in improving access and containing health care costs. As noted earlier, the history of antitrust in health care has shown that the application of antitrust in this area has provided significant benefits to health care markets by permitting innovations that promote efficiency and lower costs. If the exemptions currently being propounded were adopted, these benefits and the opportunity for others would be largely eliminated.

[53] The concern, of course, is that an exemption will be inadvertently created when none is warranted or created too broadly when a narrower exemption would suffice.

[54] An understanding of implied immunities and express exemptions is particularly important with respect to global budgets, voluntary price controls, and mandatory rate regulation which have been discussed in conjunction with health care reform proposals. While one of the purposes of health care reform is to contain costs, price regulations or other exemptions such as price negotiations among providers will interfere with the competitive market place and cause pricing to be unrelated to either supply or demand. In addition, voluntary restraints agreed to on a cooperative (rather than unilateral) basis by competitors may pose a significant antitrust risk. See generally United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 225-28 (1939) (pricing restraints encouraged by the federal government in the oil industry were irrelevant to price fixing scheme); Consumers Union of United States, Inc. v. Rogers, 352 F.Supp. 1319, modified and aff'd, 506 F.2d 136, 144 (D.C. Cir. 1974) (executive branch without authority to exempt voluntary restraint agreements among foreign steel producers from antitrust laws).

[55] The foundation for state action immunity is Parker v. Brown, 317 U.S. 341 (1943), where the Supreme Court held that the Sherman Act was not designed to prohibit acts by states in their capacity as a sovereign. Recognizing the principles of federalism, the Court noted: "In a dual system of government, in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not likely to be attributed to Congress." Id. at 352.

whereby the state either itself acts to regulate the market in place of competition or actively supervises regulatory actions of private parties.

For state action immunity to be found, a state legislature (or the state in some other capacity acting as a sovereign) must clearly articulate and affirmatively express as state policy a regulatory system designed to displace business freedom and competition and the state must actively supervise the conduct.[56] If the regulatory system established by the state involves private as well as governmental action, an additional requirement -- that the state supervise the private conduct -- is required.[57] Most recently, the Supreme Court has explained that the state supervision required for private conduct must be "active" and "participatory;" it must include "[a]ctual state involvement, not deference to private [anticompetitive] arrangements under the auspices of state law . . . ."[58] Judicial review is not adequate state supervision.[59] Mere "negative option" review by state agencies is not sufficient to invoke the immunity.[60] Thus, the Court continues to emphasize that states are not empowered to repeal federal antitrust laws except when they replace competition with a pervasive, supervised state regulatory system.

State action immunity may be relevant to health care reform area in two ways. First, to the extent that the health reform program creates (or suggests that states create) state governmental bodies to function in health care markets (for example, governmental Purchasing Alliances), state action may immunize their activities, or activities that they supervise, from the antitrust laws. Thus, to the extent that such bodies are created by the new program, care should be taken to consider carefully whether state action will apply and whether that is the intent.

Second, absent a federal legislative restriction, states will remain free to enact state legislation that could thwart the objectives of the health reform package. Currently, several states have enacted, or are considering, legislation to create state regulatory bodies that would exempt certain hospital collaborative arrangements from antitrust scrutiny. To prevent establishment of inconsistent state programs or programs that would eliminate the competition anticipated by the health care reform package, the health reform legislation could specify that the health reform legislation limit a state's ability to enact inconsistent regulatory legislation.[61]

D. Specific Antitrust Rules and Guidelines

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[56] California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980).

[57] Id.

[58] F.T.C. v. Ticor Title Insurance Co., 1992-1 Trade Cas. (CCH) ¶ 69,847 at 68,015 (1992).

[59] Patrick v. Burget, 486 U.S. 94 (1988).

[60] F.T.C. v. Ticor Title Insurance Co., 1992-1 Trade Cas. (CCH) ¶ 69,847 at 68,015 (1992).

[61] "When Congress has 'unmistakably...ordained'...that its enactments alone are to regulate a part of commerce, state laws regulating that aspect of commerce must fall." Jones v. Rath Packing Co., 430 U.S. 519, 525 (1977) (citations omitted).

While antitrust laws are not a barrier to health care reform, any perception to the contrary can be effectively addressed in health care reform. Guidelines[62] could be developed that set forth the framework for competition and antitrust analysis in the delivery of health care services. Such guidelines could dispel much uncertainty about the antitrust risks of particular conduct.

For example, the guidelines may: (1) specify a minimum number of AHPs or provider groups that could operate in a particular geographic area; (2) limit the number or percentage of an area's providers that can be in an AHP; (3) establish minimum market shares below which AHPs or provider groups will be deemed to not have market power; (4) specify the percentage of consumers or other purchasers from an area that may belong to a purchasing group; (5) specify the circumstances under which providers in an AHP or provider group may allocate services among themselves in participating in a capitated plan; (6) identify the circumstances under which an AHP or provider group may lawfully exclude providers from participation; (7) indicate the circumstances under which high-tech equipment may be shared among competitive AHPs or provider groups; or (8) clarify the circumstances under which providers in rural areas may share or consolidate resources to offer comprehensive health care coverage. Whether these guidelines are necessary or desirable depends to a significant degree upon the specific terms of the forthcoming health care reform.

IV. CONCLUSION

The two principal goals of health care reform are universal access and cost containment. Health care reform seeks to achieve these goals through Purchasing Alliances. Having several competing Purchasing Alliances available to consumers in every area would preserve consumer choice and keep the Purchasing Alliances efficient and responsive to the market.

Health care reform also contemplates the formation of competing AHPs which integrate health care services and financing. As long as consumers have the option to choose between several competing integrated AHPs, these AHPs would be unlikely to present significant antitrust risk.

The antitrust laws share many of the goals of health care reform. A blanket exemption from the antitrust laws is, therefore, neither necessary nor appropriate. The antitrust laws are not a barrier to health care reform but rather a means of promoting and protecting the more innovative and cost effective mechanisms contemplated by health care reform.

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[62] Guidelines could be provided in the health care reform legislation itself or through guidelines issued by the Federal Trade Commission or Department of Justice or issued jointly by both.

PREPARED STATEMENT OF JERALD R. SCHENKEN

Mr. Chairman and Members of the Subcommittee: My name is Jerald R. Schenken, MD. I am a pathologist from Omaha, Nebraska and a member of the Board of Trustees of the American Medical Association (AMA). AMA Associate General Counsel Edward B. Hirshfeld, JD, accompanies me today.

The AMA appreciates the opportunity to address this Subcommittee regarding the current antitrust environment and its impact on the health care delivery system, both in its present form, and as it will surely evolve under the health system reform proposals that are now being considered. We believe that the focus on health system reform in the 103rd Congress provides a unique opportunity to take action on a number of viable approaches for improving access to quality medical care. As these options are explored, a reexamination of federal antitrust law and enforcement policy as applied in the health care setting is a necessary component of the debate. To this end, the AMA recommends enactment of legislative initiatives to provide clarification of the antitrust laws so that physicians are able to participate in the system in a way that promotes competition and thereby contributes to the delivery of affordable medical services to all of our citizens. The AMA does *not* seek an exemption from the antitrust laws for physicians.

ANTITRUST AND MANAGED COMPETITION

The major proposals addressing reform of the present health care system contemplate a managed competition model, with managed care plans likely to provide a substantial volume of care. While the specific design of the Administration's plan has yet to be formulated, it is clear that health care providers will be expected to work cooperatively under any new framework to create entities capable of rendering efficient, cost-effective and quality health care.

In order to realize the full potential of the responsibilities that the medical profession will be expected to assume in the emerging health care climate, physicians must be free to negotiate with managed care plans on a variety of issues without the threat of civil or criminal antitrust actions. Managed competition will demand that physicians respond collectively, in order to respond meaningfully. The ability to respond collectively, without engaging in price-fixing, boycotts, or the threat of boycotts, will become increasingly important in enabling physicians to fulfill their historic role as advocates for their patients. Thus, the AMA seeks limited, specific clarification of the antitrust laws and their enforcement to assure that physicians can fulfill the role expected of them in the reform process.

In addition, antitrust reform will be necessary in order to permit loosely integrated physician networks to exist. Such networks can be valuable in the gathering and exchange of information between physicians and managed care organizations, as well as to payers that desire access to a geographically dispersed network that covers major medical specialties. Reforms are also necessary to facilitate the formation of tightly integrated physician networks. Guidance must be provided as to the degree of integration sufficient to constitute a legitimate joint venture. Antitrust reforms are necessary to ease the burden of compliance with antitrust laws for tightly integrated networks that qualify as joint ventures. AMA proposals to reform the antitrust environment address both of these situations. (See Attachment A).

1. The Chilling Effect of Antitrust Law in the Health Care Arena

Under traditional antitrust legal analysis and enforcement activities of both the Federal Trade Commission (FTC) and the Department of Justice (DOJ), physicians who have attempted to negotiate collectively with third-party payors through a professional organization or a joint marketing venture have been subjected to criminal investigation and/or civil penalties. These enforcement efforts reflect an unduly restrictive view of the law in light of the relevant federal court decisions. The courts have increasingly come to recognize the unique role of health care providers, and are, therefore, applying a more flexible legal standard than either the FTC or the DOJ in judging collective activity in the health care arena.

The decision of the Ninth Circuit Court of Appeals in *United States* v. *Alston*[1] reflects this trend. The *Alston* case involved three Tucson, Arizona dentists who were charged with criminal price-fixing for agreeing on a revised schedule of "co-payments" to propose to four prepaid dental plans.[2] No boycott was alleged inasmuch as the dentists continued to provide services to plan patients throughout the negotiation process. The Ninth Circuit noted that health care providers negotiating with

[1] 974 F.2d 1206 (9th Cir., 1992)
[2] *Id.* at 1207

payors "face an unusual situation that may legitimate certain collective actions."[3] In particular, providers must deal with payors who "act as bargaining agents" for large groups of consumers who dictate "uniform fee schedules—anathema in a normal competitive market."[4] The court found that physicians need to be able "to band together to negotiate" in order to "level the bargaining imbalance."[5] As the court said:

> In light of these departures from a normal competitive market, individual health care providers are entitled to take some joint action (short of price fixing or group boycott) to level the bargaining imbalance created by the plans and provide meaningful input into the setting of the fee schedules. Thus health care providers might pool cost data in justifying a request for an increased fee schedule. Providers might also band together to negotiate various other aspects of their relationship with the plans such as payment procedures, the type of documentation they must provide, the method of referring patients and the mechanism for adjusting disputes. Such concerted actions, which would not implicate the per se rule, must be carefully distinguished from efforts to dictate terms by explicit or implicit threats of mass withdrawals from the plans.[6]

The *Alston* decision clearly demonstrates recognition by the courts of the need to clarify the application of the antitrust laws to physician/payor negotiations. The ruling anticipates an environment in which health care professionals are permitted to advocate their views on how to reduce costs without sacrificing quality. However, under current policy, physicians who engage in conduct such as that described in *Alston,* could reasonably expect to be prosecuted by the Department of Justice, the FTC, and/or private parties. While other courts may also recognize the decision in *Alston,* physicians across the country would fear protracted litigation to vindicate their activities. Procompetitive activities by physicians, such as joint marketing arrangements, should be expressly permitted under the law so that physicians can deliver quality health care in an efficient manner.

For at least ten years, government enforcement agencies and private antitrust counsel have sent physicians a consistent message: collective actions by physicians, whether procompetitive or not, carry a high level of antitrust risk. This advice is not mere conjecture; it is based on a consistent pattern of enforcement by the FTC and the DOJ. A review of recent case law as applied to a number of typical fact patterns reveals the unnecessary antitrust restrictions that are now present in the health care marketplace. (See Attachment B).

2. Legislative Solutions

To address the foregoing concerns, the AMA strongly urges clarification of the antitrust laws—not an exemption. Although the clarification we seek could be accomplished within the authority of the enforcement agencies, statutory action would be the most effective solution. A statutory scheme permitting health care providers to join together to collectively negotiate with third-party payors with respect to the operation of a managed care plan, its administrative procedures, and reimbursement schedule will act to promote competition and facilitate meaningful health care reform. In that context, we offer the "Physician-Health Plan Negotiations Act of 1993" which would encourage and facilitate physician negotiations with managed care plans and other third-party payors. (See Attachment C) This model Act would establish safe harbors for physicians who collectively present their views to managed care plans *without engaging in price-fixing, boycotts, or the threat of boycotts.* The Act would also require physician input into administration, coverage and payment policies of managed care plans. Physicians would, therefore, be free to approach payors collectively to provide appropriate input on fees and other payment-related issues.

In addition, physicians must be permitted to act on behalf of their patients on issues regarding access to and quality of care. In a managed care setting, physicians can provide both their medical expertise and practical experience in formulating and implementing sound policies. For example, physicians can offer the most salient advice on the appropriate physician to patient ratio in order to provide optimal patient care in particular settings. Where managed care decisions may negatively impact on the quality of patient care, physicians can serve as the strongest advocates of patient interests by recommending other alternatives.

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[3] *Id.* at 1214
[4] *Id.*
[5] *Id.*
[6] *Id.*

The AMA believes that the antitrust laws should not prohibit physicians affiliated with, but not employed by, a managed care plan from collectively providing information to the plan on such issues as medical review criteria, quality assurance programs, coverage, medical policy and reimbursement decisions. In this context, we present the "Managed Care Improvement Act of 1993," a model Act that would require managed care plans to establish physician committees to advise plan management on medical review criteria, quality assurance issues, grievance mechanisms, and certain financial and administrative matters. (See Attachment D) This model Act would also provide protection for physicians who provide good faith advice and recommendations to a managed care plan. It would further provide antitrust immunity for physicians who in good faith participate in collective activities in developing position statements relating to their relationships with the plan.

In addition, there have been extensive discussions over the years about providing hospitals with some level of antitrust protection so that they can combine to more effectively use expensive health care resources. In developing such legislation, we urge that consideration be given to protection for physicians and other providers who may be locked out of the market when services are combined. If used properly, a combination of community resources will yield cost-effective and practical results. However, such combinations should not be allowed where they are used to selectively exclude practitioners, thereby decreasing competition.

PROFESSIONAL SELF-REGULATION

The current antitrust statutes and enforcement activities have acted to severely restrict appropriate professional self-regulation and discipline by the medical community as well. Most state and county medical societies have by-laws that provide for standing committees designed to mediate and resolve patient grievances and to discipline members that engage in unethical conduct. Some of the societies hear patient complaints about fees. However, these committees have become inactive or underused in many, if not most, geographic areas. When medical societies have tried to exert their influence on economic matters, antitrust provisions have thwarted their efforts. The AMA has filed a petition with the Federal Trade Commission (See Attachment E) seeking to remove limitations that restrict the medical profession from pursuing additional efforts to police itself. To this end, the AMA also supports H.R. 47, introduced by Representative Bill Archer (R-TX).

In our view, carefully designed immunity from the federal antitrust laws for medical self-regulatory entities engaged in enforcement activities designed to promote the quality of health care, which would be created under H.R. 47 and which were also incorporated into S. 3348, sponsored by Senator Hatch in the 102nd Congress, would advance progress in a number of areas. Under this type of statutory scheme, standard setting and enforcement activities that would be permitted to flourish without the threat of undue legal sanction would include peer review, technology assessment, risk management, accreditation, and the development and implementation of practice guidelines and ethical codes.

1. Professional Peer Review of Fees

The Federal Trade Commission has issued a number of advisory opinions regarding the operation of professional peer review of fees. These opinions have recognized that properly managed programs can yield procompetitive benefits. The benefits cited by the FTC include an increased flow of information about physician fees to patients, enabling them to compare fees when selecting a physician. Such programs can also act as an inexpensive and efficient method to resolve fee disputes.

In accordance with FTC guidelines, the AMA has filed a petition for an advisory opinion on professional fee peer review. Our program would modify these guidelines, however, to involve mediation of complaints about fees, mandated physician participation, and the ability to discipline physicians for fee gouging. Under this program, state or county medical societies would perform most of the professional review, with the AMA acting as an appellate body for decisions and opinions of the state societies. This type of enforcement activity would serve to protect patients, increase their confidence in the belief that they will be treated fairly, and facilitate the operation of the market for physician services as well.

2. Health Care Fraud and Abuse

The AMA has undertaken a number of initiatives designed to eliminate health care fraud and abuse. We have participated with the FBI in training agents to ferret out fraud and abuse, established a toll-free hotline so that physicians and medical societies may report fraud, and worked actively with the Federation of State Medical Boards to identify physicians who cross state boundaries to defy the law.

In recent Congressional testimony, the AMA urged appropriate application of the antitrust laws to permit information exchange between insurers and to afford immunity to those who provide information in good faith leading to prosecution and conviction of health care offenses. We believe that such an application of antitrust laws would contribute to the elimination of health care fraud and abuse.

CONCLUSION

The AMA strongly recommends changes to the current antitrust environment, particularly as health system reform will dictate the use of new procompetitive approaches for the delivery of affordable medical care. Managed competition will require the incorporation of substantial efficiencies, making cooperation among health care providers and coordinated activity on behalf of patients imperative. Health care antitrust relief will permit physicians to form networks to address the changes that will inevitably occur and provide valuable input into the policymaking activities of managed care plans. Appropriate legislative solutions, such as those we have recommended today, will contribute to the success of any model for health system reform that is ultimately adopted.

ATTACHMENT A—AMERICAN MEDICAL ASSOCIATION PROPOSED ANTITRUST AND MANAGED COMPETITION

The American Medical Association (AMA) has submitted substantial materials to the White House Task Force Working Groups (WHTFWG) about the need for antitrust reforms to facilitate the formation of physician networks. The following is an additional submission based upon the reactions that we have received from the WHTFWG to date. In particular this submission addresses the need for antitrust reforms to facilitate "tightly integrated" physician networks as well as "loosely integrated" physician networks. This submission does not repeat our previous materials or restate our proposals. Instead it is directed at responding to the issues raised by the WHTFWG.

THE NEED FOR COOPERATIVE PHYSICIAN NETWORKS UNDER MANAGED COMPETITION

The managed competition proposal that the WHTFWG is assembling is designed to reduce costs while maintaining or enhancing quality by fostering competition between vertically integrated managed care plans. The successful operation of these plans depends on a high degree of cooperation among the physicians that participate in them. In most models of these plans, physicians are expected to cooperate in the following ways:

1. Coordination in the referral of patients to physicians in different specialties and the referral of patients to other types of providers as needed.
2. Cooperation in the total management of patient needs, with one physician responsible for assessing total patient needs and monitoring the patient as the patient sees other providers.
3. The development and implementation of protocols and guidelines for the management of patients.
4. The development and operation of information systems to monitor quality and the management of costs.
5. Cooperation in educational processes designed to help physicians use information about quality and cost outcomes to improve results.
6. Credentialing processes to assure the quality of providers that enter and remain in the network.
7. The operation of joint administrative procedures to realize economies of scale in network administration.
8. The coordination of investment in and usage of equipment and facilities to realize economies of scale.
9. The operation of patient safety and risk management programs.
10. The purchase of medical supplies and other products, such as liability and stop loss insurance.

This is not an exhaustive list—there are numerous other areas in which cooperation is necessary or desirable, many of which are difficult to anticipate. The more creative and innovative the network in finding areas of cooperation that result in efficiencies, the more successful it is likely to be. The higher or "tighter" the degree of cooperation in these matters, the greater the potential for efficiencies.

There must also be a high degree of cooperation in developing the financial arrangements that underlie the physician component of a vertically integrated managed care plan. Sophisticated financial and actuarial analysis is necessary to de-

velop physician compensation arrangements that provide incentives to maintain quality while controlling costs, that are at levels which allow the plan to remain cost competitive with other plans, and that allow the plan to attract enough competent physicians to treat potential beneficiaries.

The AMA believes that vertically integrated plans will be more successful in reducing costs while maintaining and enhancing quality if physicians have a strong role in their organization and in the development of their operational policies and procedures. Physicians have always been a vibrant source of creative initiative and can make substantial contributions to the search for ways to deliver high quality care more efficiently. However, they are not at their best if simply forced to take direction from a limited group of non-physician managers.

Physicians will be committed and make their best contributions if they have the autonomy necessary to implement their concepts. They will have the autonomy necessary for them to embrace the goals of reducing costs while enhancing quality if they are allowed to organize themselves into the cooperative arrangements required to succeed under managed competition. Further, physicians should not have to merge their practices with other groups in order to have a voice in managed care—independent physicians who are allowed to organize in ways that preserves their individual autonomy can make substantial contributions to the goals of health system reform.

THE ANTITRUST LAWS AND PHYSICIAN NETWORKS

Achievement of the high degree of cooperation contemplated under managed competition without violating the antitrust laws is not a problem for physicians who have fully integrated their practices, such as physicians who are members of large group clinics that contract with managed care plans or operate their own vertically integrated managed care plan. Antitrust compliance is also not a problem for physicians who are employees of vertically integrated managed care plans or a private institution such as a hospital that contracts with managed care plans. These groups of physicians are considered to be parts of single entities under the antitrust laws and therefore incapable of conspiring with one another.

However, the vast majority of practicing physicians are in solo practice or in small groups. Physicians who are in independent practice cannot achieve the high degree of cooperation necessary to be part of a successful managed care plan without coming under strict antitrust scrutiny. If they want to retain their independence, they have a choice between becoming independent contractors with a vertically integrated managed care plan, or cooperating to form a group that contracts with vertically integrated plans or which becomes a managed care plan. If they become independent contractors, there are strict limits under the antitrust laws on their ability to independently develop cooperative arrangements or to negotiate with the plan as a group. As a practical matter, the plan itself determines what the cooperative arrangements will be and implements them by directive, often without any prior input from the participating physicians.

If independent physicians form a network to develop cooperative arrangements, they face strict antitrust rules without clear guidance on how to comply with those rules. In order to jointly set prices for their arrangements, the network physicians must "integrate" their practices sufficiently to be considered a legitimate joint venture under the antitrust laws. A loosely integrated physician network might not be considered sufficiently integrated to be legal under the antitrust laws. As the degree of integration becomes tighter, the more likely it is that the network will be considered a legitimate joint venture.

However, the nature and degree of integration necessary to qualify as a joint venture is not well defined. Networks which have not integrated are clearly not joint ventures, and networks with a very high degree of integration that offer a product of value to managed care organizations clearly are legitimate, but uncertainty plagues the gradations in between. Further, even when a network is tight enough to qualify as a legitimate joint venture, other antitrust issues remain. The network cannot have too much market power, and agreements in restraint of trade that are ancillary to the formation and operation of the network must not restrain trade more than is necessary to implement the legitimate purposes of the network. Resolving these issues requires complex analysis, and even then it is rarely possible to be certain that all antitrust rules are being complied with.

These antitrust rules impose a significant burden on physician networks, even if tightly integrated enough to be considered a legitimate joint venture. An antitrust lawyer must become an integral part of the management team. That imposes high costs at a time when the achievement of savings is critical. In addition, the need to consult with the antitrust attorney disrupts the decision making process and

makes it more difficult for the network to react. The rules themselves reduce the flexibility of the networks, and that also makes it difficult for the network to react to new developments in its market.

In summary, physicians in independent practice who want to become part of an effective physician network that is competitive in a managed care environment while complying with the antitrust laws, have the following choices: (1) sell or merge their practices with other physicians to form a network, (2) become an employee of a health plan or other entity that maintains a physician network, (3) become a controlled independent contractor, or (4) become part of a legitimate physician sponsored joint venture.

The first option gives physicians the maximum flexibility and voice, but it requires a loss of independence. The second option does not provide physicians with flexibility or independence, but it does allow physicians to have a voice if they succeed in organizing under federal labor laws. The third option results in a limited loss of independence, but does not allow physicians to have an effective voice. The fourth option allows for independence and a voice, but it is a status for which the rules of attainment are highly uncertain. Further, once achieved there are additional uncertainties about antitrust compliance that may inhibit creative initiatives. The inflexibility and the high cost of compliance with the antitrust laws put physician sponsored networks at a competitive disadvantage with fully integrated physician networks and health plan sponsored networks.

THE REASONS WHY THE ANTITRUST LAWS ARE BURDENSOME FOR TIGHTLY INTEGRATED PHYSICIAN NETWORKS

The AMA understands that the WHTFWG is aware of the antitrust problems that independent physicians face in organizing networks and is considering antitrust reforms for "loosely integrated " networks that would negotiate fees with payers. However, the AMA understands that the WHTFWG does not believe that the antitrust laws need to be modified for tightly integrated physician groups, as those groups are considered to be legal under the antitrust laws.

As stated above, the AMA agrees that under the current enforcement positions of the Federal Trade Commission (FTC) and the Antitrust Division of the United States Department of Justice (DOJ), tightly integrated physician networks are more likely than loosely integrated networks to be considered in compliance with federal antitrust laws. However, also as stated above, this area is still plagued with uncertainty, and it is rare to find an antitrust attorney who will opine that all aspects of even a tightly integrated physician network is in compliance with the antitrust laws. The inherent uncertainty in this area, the high cost of antitrust counsel, and the inflexibility imposed on decision making discourage the formation of networks and add unnecessary costs.

This section will explain the reasons why the law is so complex and uncertain.

To begin with, the sources of guidance about antitrust law are unusually obtuse. An antitrust attorney needs to be familiar with case law and the enforcement positions of the two federal agencies with primary responsibility for enforcing federal antitrust laws, the Federal Trade Commission (FTC) and the Antitrust Division of the United States Department of Justice (DOJ). Case law is voluminous, inconsistent, and always evolving. An attorney has to develop a sense for what direction case law is likely to take in the future. To know the FTC/DOJ enforcement positions, an antitrust attorney needs to be familiar with DOJ business review letters, FTC staff advisory opinions, speeches by officials of the AMA and the FTC, the D0J/FTC merger guidelines, and current enforcement actions. Being aware of all of these sources and knowing how to interpret them is an art form.

Serious problems arise from the decision of the Supreme Court in *State of Arizona* v. *Maricopa Medical Society,* 457 U.S. 332 (1982). That case involved a challenge to managed care entities developed by two county medical societies. These entities developed physician networks, reviewed the medical necessity and appropriateness of services provided by network physicians, handled claims payments for services provided by network members, and developed a fee schedule for services provided by network physicians. The networks were offered to insurers, and network members agreed to accept the fees allowed by the schedule as full payment for services provided beneficiaries of insurers that contracted with the entities, and not to balance bill those beneficiaries.

The *Maricopa* decision found that both of these entities were engaged in *per see* illegal price fixing. The case caused enormous consternation among entrepreneurs and providers that were trying to organize managed care entities and provider networks. The literal language of the opinion appears to bar arrangements whereby independent providers agree to discount their usual charges or agree to capitation

as part of a managed care organization. It was universally agreed that the case barred such agreements among providers, and it was uncertain whether it was possible to have a broker or entrepreneur achieve the same result by developing individual agreements with providers that wanted to start a managed care entity. There were also concerns about whether employers could develop coalitions to negotiate with providers for discounted charges as that might constitute price fixing.

It appeared, after *Maricopa*, that there were only two ways to organize managed care entities that were assured to be legal under the antitrust laws. One was to employ physicians to provide care under a managed care plan, the other was for providers or payers to contribute capital to a new entity and "share the risks of lose as well as the opportunity for profit." If capital contributions and risk sharing were accomplished, then the arrangement would be treated as a new business, and considered to be a single entity under the antitrust laws as opposed to a combination of competitors. However, the latter option meant that provider participants in a network would also have to be owners of an entity in which they contributed capital and shared the opportunity for profit and the risk of loss. An important question left open by *Maricopa* was the extent of investment in a new entity necessary for it to be considered a legitimate joint venture. This question remains vague and unresolved today.

After the *Maricopa* case, the DOJ issued a series of business review letters and DOJ officials made a series of speeches about managed care entities. In those materials, the DOJ developed the joint venture analysis of managed care organizations that was first described by Robert H. Bork in chapter 13 of *The Antitrust Paradox*, Basic Books, Inc., New York (1978). That analysis allows for joint venture treatment of "contract integrations," where independent competitors enter contract arrangements that do not involve capital contributions or risk sharing, but which result in a new product or economic efficiencies that are of value to the market.

After the DOJ developed this line of analysis, four problems emerged. They are as follows:

A. *The DOJ position Departed from Maricopa.* The analysis advanced by the DOJ departed from the literal language of the Supreme Court in *Maricopa*, and it was uncertain as to how federal courts would react when faced with a choice between following the DOJ analysis or the *Maricopa* opinion. Antitrust attorneys were uncertain about the extent to which the DOJ analysis could be relied upon.

B. *Conflicting DOJ and FTC Positions.* Second, as the FTC issued staff advisory opinion letters and engaged in enforcement actions, it became apparent that the FTC disagreed with the DOJ analysis and believed that the literal language of the *Maricopa* opinion should be more closely followed. This difference of opinion still appears to exist, although it now appears that the FTC will agree with the DOJ analysis provided that the physician network involved is capitated, even though capitation by itself is insufficient to meet the literal language of *Maricopa*. However, if the network is not capitated, the FTC reverts back to the literal language of *Maricopa*.

The difference of opinion between the FTC and the DOJ is troubling. Indeed, under the DOJ criteria being applied today, the managed care entities at issue in the *Maricopa* case might well be viewed as legitimate joint ventures. As stated earlier, those entities engaged in review of the medical necessity and appropriateness of services provided by members of their physician networks, provided claims payment services, and polled member physicians to develop a fee schedule that the network members would accept as payment in full without balance billing. The sum total of those activities may well constitute sufficient integration to pass muster under a DOJ review.

In contrast, under FTC criteria, the managed care entities at issue under *Maricopa* would continue to be viewed as *per se* illegal because they involve the setting of price by physicians who have not pooled capital and who are not compensated with capitation. If physicians who participate in a physician sponsored managed care network are paid on a fee for service basis, the FTC probably would not consider the entities to be legitimate joint ventures. It would treat the entities as unintegrated physician networks.

C. *No Standards for What Constitutes a Sufficient Integration.* While the DOJ analysis expanded the range of possible types of managed care organizations and provider networks, the limits of the range of legality were not at all clear and still are not clear. There are very few standards for when a contract integration results in a sufficiently new product of value to the market, or achieves a sufficient amount of efficiencies, to be considered a legitimate joint venture. There are some broad principles for what is necessary, but no guidance about how to measure the amount

of integration that is considered to be adequate. The analysis is highly fact specific and therefore subjective.

D. *Antitrust Issues that Remain After Joint Venture Status is Attained.* Fourth, once a managed care entity or network is considered to be a legitimate joint venture, there are still more antitrust hurdles to cross. One is whether the combination of competitors in the joint venture amounts to an excessive degree of market power. Measurements of market power begin by defining the product market and the size of the geographic market in which the network participates. Market determinations are a highly uncertain process under case law. The process is highly fact specific and subjective.

At one point the DOJ created a market power safe harbor—it stated that physician networks that accounted for less than 35% of the physicians in a geographic market would not be considered to have excessive market power. Subsequently, however, the DOJ repudiated this safe harbor and announced that the legality of market power would be evaluated under the DOJ/FTC merger guidelines. These guidelines are lengthy and very complex—Even antitrust attorneys have difficulty understanding them and how to apply them. In addition, the interpretation of the merger guidelines by the FTC and the DOJ is constantly shifting as policy positions in those agencies evolve.

An example of the problem of discerning DOJ/FTC enforcement policy in determining market power is a footnote that appeared in a published speech given by James Rill, a former Assistant Attorney General in charge of the DOJ Antitrust Division. The footnote stated, in essence, that the percentage of physicians in a market that participate in a network would be determined by aggregating the number of physicians participating in each network that operated in the geographic market. Since individual physicians often participate in more than one network, that method would allow individual physicians to be counted more than once in arriving at the base figure used to calculate the percentages for each network. The resulting percentage would then be used to evaluate whether a physician had too much market power. ("Antitrust Enforcement Policy and the Treatment of Horizontal Price Restraints: Lessons for the Health Care Industry," Remarks of James F. Rill, Assistant Attorney General, Antitrust Division U.S. Department of Justice, February 15, 1991, at page 10).

However, seasoned antitrust attorneys that follow DOJ enforcement policy closely do not know whether this test has been used by the DOJ since the speech was given, what weight the test has in an overall evaluation of market power, and whether the test can be relied upon in advising whether a proposed network would be legal under the antitrust laws.

Another legal hurdle that has to be crossed by a legitimate joint venture is whether all agreements in restraint of trade that are ancillary to the joint venture are necessary to achieve its procompetitive purposes. Ancillary agreements include matters such as agreements on the price at which health care services provided through the venture will be sold, agreements on the territories that participants in the joint venture will serve, agreements on the medical protocols that will be followed by participants in the venture, and other matters. An ancillary agreement is considered to be unnecessary if it does not help define or implement the new products or efficiencies that make the joint venture procompetitive. There are no clear standards for evaluating whether an ancillary agreement in restraint of trade is necessary or not.

Further complicating the issue is the relationship of the ancillary agreement to the market power of the network. For example, one ancillary agreement that is commonly evaluated is whether a tightly integrated physician network can bar its member physicians from joining other networks. That might be legal if the network does not have too much market power, but if the network has a large percentage of the physicians in a geographic market, that ancillary agreement might be illegal. See, e.g., *U.S. Healthcare. Inc.* v. *Healthsource. Inc.,* 1993–1 Trade Cases §70,142 (1st Cir., 1993).

By way of further example, a network might attempt to achieve economies of scale by agreeing upon which physicians in the network would invest in certain diagnostic equipment or facilities. If there is an oversupply of the equipment involved in the market, or if there are plenty of other providers willing and able to introduce the equipment into the market, the ancillary agreement might be legal. But if that agreement tended to prevent entry of equipment into use in a market which did not have an oversupply, or in a market in which there were no other providers that willing and able to invest in the equipment or facilities, that might be an illegal ancillary agreement.

For all of these reasons, seasoned antitrust attorneys are unable to give concrete advice to providers who wish to develop managed care entities or provider networks,

even if those networks will be tightly integrated. Some of the providers are being advised that if they proceed in good faith to organize a managed care network and do not have much market power, they will probably not be prosecuted. However, no assurances could be given that the venture would be found legal if challenged. Other providers are being advised that if they create a joint venture in which they set fees, they risk an investigation under *Maricopa*, possibly even a criminal prosecution.

CONCLUSION

In summary, advising physician networks on antitrust issues is fraught with peril and uncertainty, even if the network is tightly integrated. The uncertainties add significant legal fee expenses to the formation and operation of a network. The uncertainties and the expenses are a factor that discourages some physicians from organizing networks. This problem needs to be corrected in order to facilitate the evolution of creative ways of delivering health care services, especially when initiated by providers.

As the WHTFWG recognizes, the antitrust laws need to be reformed consistent with the proposals of the AMA in order to allow loosely integrated physician networks to exist at all. Under present interpretations of the antitrust laws by the FTC and the DOJ, loosely integrated networks that do not have enough indicia of integration to be classified as legitimate joint ventures are likely to be prosecuted. However, loosely integrated physician networks can be valuable in the gathering and exchanging of information between physicians and managed care organizations, and they can be valuable to payers that want ready access to a geographically dispersed network that covers the major specialties.

Reforms are also necessary to facilitate the formation of tightly integrated physician networks. Clear guidance needs to be provided about what degree of integration is sufficient to pass muster as a legitimate joint venture, and antitrust reforms are necessary to ease the burden of compliance with the antitrust laws for tightly integrated networks that do qualify as joint ventures.

ATTACHMENT B—ANTITRUST OBSTACLES TO PHYSICIAN PARTICIPATION IN PROCOMPETITIVE COLLECTIVE CONDUCT: SOME SPECIFIC EXAMPLES

1.

A group of 100 physicians forms an IPA designed to contract directly with self-insured employee benefit plans. The IPA includes a majority of the members of the medical staff of one of the leading hospitals in town. By contracting directly with the plans, the IPA offers the plans the opportunity to cut out the insurer or HMO middleman, and thereby reduce costs. The IPA also offers broad geographic and specialty coverage—*i.e.*, its member physicians are located throughout the community and practice in all medical specialties. Moreover, the IPA enables the plans to enlist these physicians efficiently by signing a single contract.

Each of the physicians continues to maintain an independent practice outside the IPA. In addition, each of the physicians belongs to a variety of plans outside the IPA. For services performed pursuant to a contract between the IPA and a plan, the physicians are paid directly by the plan on a discounted fee-for-service basis. Payment levels are based on the Medicare fee schedule, adjusted by a percentage negotiated between the individual plan and a consultant of the IPA. The consultant is retained by the IPA's Board of Directors.

The IPA does not submit bills or get paid any amounts by third party payers. Payment flows directly from the payer to the individual physician. The physicians do not share the risk of overutilization. There are no withholds, and to date the IPA has not accepted any prepaid or capitated contracts.

Antitrust Risks: The physicians in the IPA may be charged with criminal or civil price-fixing. Federal antitrust enforcement agencies forbid physicians from agreeing on a fee schedule for an IPA or other joint venture unless the venture is sufficiently "integrated." They have viewed financial risk-sharing as a *sine qua non* of integration. Here, the physicians in the IPA do not directly share financial risk in the sense required by antitrust agencies because the IPA does not charge on a capitated or other prepaid basis. Accordingly, the fee schedule may well be viewed as an illegal agreement on price among competing physicians.

The fact that the IPA uses a consultant, rather than negotiating directly with payers through its Board, is probably irrelevant. The consultant is retained by the Board, and is subject to the Board's ultimate direction. Antitrust officials are likely to view the consultant as an agent of the IPA, who is reaching an agreement on price on behalf of the member physicians.

See, e.g., Arizona v. *Maricopa County Medical Society,* 457 U.S. 332 (1982); *Southbank IPA, Inc.,* FTC Docket No. C–3355, 57 Fed. Reg. 2913 (January 24, 1992) (consent order); *Preferred Physicians, Inc.,* 110 F.T.C. 157 (1988) (consent order).

2.

Large employers in a mid-sized metropolitan community form a purchasing cooperative to contract for hospital and medical services. Together, the health benefit plans operated by the employers cover 50% of the covered lives in the community. In an effort to avoid the inefficiency of negotiating individual contracts with numerous small physician groups, the cooperative wants to enter contracts with a physician network that includes a broad range of geographic and specialty coverage. However, there are no group medical practices of sufficient size to meet the needs of the cooperative's insureds. Accordingly, 150 physicians form an alliance for the purpose of negotiating contracts with the cooperative and any similar purchasing groups that may be formed.

Antitrust Risks: The physicians may be accused of civil or criminal price-fixing, particularly if: (a) the network rejects the offers made by the purchasing cooperative, (b) the physicians are paid on a fee-for-service basis, (c) the network is exclusive—*i.e.,* the physicians do not join other alliances. The antitrust laws may exert significant pressure on the physician alliance to accept the terms offered by the purchasing cooperative. This is so even though the cooperative has significant purchasing power, and even though the alliance was formed to meet the need of the cooperative for a large network of physicians.

See, e.g., Arizona v. *Maricopa County Medical Society,* 457 U.S. 332 (1982); *United States* v. *Alston,* 974 F.2d 1206, 1214 (9th Cir. 1992); *United States* v. *Greater Bridgeport IPA. Inc.,* 7 Trade Reg. Rep. (CCH) ¶ 50,741 (1992) (DOJ consent order).

3.

A group of 120 physicians in a three-county area forms a "clinic without walls." In essence, the physicians create a multispecialty group practice with numerous locations. Each participating physician's office becomes a separate location for the group practice. Each physician contributes capital to the venture. The venture negotiates contracts with third party payers. Some of the contracts provide for payment on a capitated basis.

Collectively, the physicians represent less than 25% of the total physicians in the three-county area. However, in certain specialties (*e.g.,* obstetrics/gynecology and general surgery) the venture includes 65% or greater of the physicians in the community.

Antitrust Risks: The formation of the "clinic with walls" may be challenged under §7 of the Clayton Act. Antitrust officials have repeatedly stated that, in analyzing the market power of joint ventures involving physicians, they will look not only at the venture's share of the total physician market (here, less than 25%) but also its share of relevant medical specialty markets. Because this venture includes a relatively high market share with respect to certain specialties, the venture could be subject to liability or forced dissolution.

See, e.g., Address by James F. Rill to the National Health Lawyers Association (Feb. 15, 1991).

4.

A medical specialty society contracts with an independent consulting firm to "restudy" the relative values developed by HCFA for payment of certain medical procedure codes under the Medicare RBRVS. The consulting firm collects data by surveying physicians concerning the amount of time and work involved in these medical procedures. It follows the same basic survey method that HCFA used in developing its relative values, with some changes to correct perceived methodological flaws in the HCFA approach.

The consulting firm then analyzes the data, and develops a list of suggested relative work units involved in various procedures. These work units are a critical component of an RBRVS. Some of the work units are lower than those developed by HCFA, but most of them are higher. The consulting firm also supplies a written report explaining why it believes that its relative work units are more accurate and defensible than those developed by HCFA.

The specialty society reviews the consulting firm's findings and decides to "endorse" the study. Specifically, the specialty society sends the study out to HCFA and to other governmental and private third party payers. Private payers are included

on the list because many of them are considering use of the Medicare fee schedule as the basis for their own payment schedules. The specialty society includes a cover letter asking that the payer carefully consider the consulting firm's findings.

The specialty society also provides the study (including its list of relative work units) to individual members of the society who request a copy. All members are made aware of the existence of the study (through society newsletters, etc.), but they are not routinely sent a copy.

Antitrust Risks: In the late 1970s and early 1980s, the Federal Trade Commission obtained several consent decrees against medical societies that had developed relative value scales. The Commission apparently continues to believe that these activities raise a serious risk of anticompetitive effects. The Compliance Division of its Bureau of Competition has taken the position that a restudy by the American Academy of Orthopaedic Surgeons to critique the Medicare RBRVS violates a consent decree prohibiting the Academy from developing relative value schedules. On the Commission's reasoning, moreover, efforts to question the Medicare RBRVS may be viewed as price-fixing.

See, e.g., American Academy of Orthopaedic Surgeons, FTC Docket No. C–2856; *American Society of Internal Medicine, 105 F.T.C. 505 (1985); See contra, United States* v. *American Society of Anesthesiology,* 473 F. Supp. 147 (S.D.N.Y. 1979).

ATTACHMENT C—PHYSICIAN NEGOTIATIONS WITH THIRD PARTY PAYERS: PROPOSALS FOR ANTITRUST REFORM

In the last decade, the economics of health care delivery in America have changed dramatically. Health care markets today are characterized by large managed care plans that are taking aggressive actions to reduce their costs. Some cost-cutting is, of course, not only appropriate but desirable. However, excessive concern for costs can curtail the availability of medically appropriate services to patients and diminish the quality of those services. For this reason, our society should encourage active input to payers from physicians who are concerned about the availability and quality of medical services for patients.

Current legislative proposals for health care reform are designed to enable payers to exercise even greater bargaining power. At the same time, these proposals appear to assume that physicians will have a significant role to play in shaping policy under a revamped health system. In this regard, the proposals follow the approach to health care payment and delivery that has been adopted in other major industrialized nations such as Germany, France, Canada, and Australia. These countries each include a structured role for physician negotiations as a critical feature of their health care delivery systems.[1]

By contrast, federal antitrust enforcers are taking the position that physicians who join together to negotiate with insurers and other third party payers over reimbursement issues violate the antitrust laws. Dozens of physicians who have participated in joint negotiations have been subjected to criminal investigations. Others have been exposed to substantial civil penalties. Countless others have been deterred from engaging in negotiations with payers by the threat of antitrust sanctions.

The American Medical Association ("AMA") believes that federal antitrust policy is on a collision course with health care reform. If reform is to succeed in ensuring access to high quality, affordable health care for all Americans, physicians must have a strong, collective voice on issues relating to the delivery of and payment for care. As the United States Court of Appeals in San Francisco recently observed, health care providers must be permitted to act collectively to "level the bargaining inbalance" created by payers.[2] In particular, providers should able to "band together to negotiate" with payers regarding the operation of a plan, its administrative procedures, and its reimbursement schedule.[3]

Under the antitrust laws as currently interpreted and enforced, however, physicians who engage in collective negotiations are threatened with criminal prosecution or costly civil litigation. This state of affairs is unacceptable as a matter of health care policy, proper antitrust analysis, and fundamental fairness. Antitrust reform in health care therefore is an issue that demands immediate attention.

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[1] *See, e.g.,* United States General Accounting Office, *Health Care Spending Control: The Experience of France, Germany, and Japan* 34 (1991); W. Glaser, *Health Insurance in Practice* 251–52, 485–87 (1991); W. Glaser, *Health Insurance Bargaining* (1978).

[2] *See United States* v. *Alston,* 974 F.2d 1206, 1214 (9th Cir. 1992).

[3] *Id.*

In this paper, the AMA sets forth several specific proposals that are intended to promote competition while facilitating meaningful health care reform. In particular, this paper explains why:

1. Physicians acting through their medical society or other professional group should be permitted to agree on a reimbursement level to propose to a third party payer;
2. Physicians should be permitted to form joint marketing networks to negotiate contracts with employers and other purchasers of medical services, whether or not the physicians share direct financial risk;
3. Physicians who practice in a community in which there is a powerful payer or coalition of payers should be permitted to form negotiating groups of reasonable size to bargain collectively with the payer; and
4. Physicians who are affiliated with a managed care plan should be encouraged to provide their good faith, collective input to the plan on such topics as coverage decisions, quality assurance matters, and administrative and reimbursement issues—without fear of antitrust liability.

These proposals can be implemented through changes in current enforcement policy. As a practical matter, however, legislative action may be necessary in order to effectuate them. Accordingly, a model statute embodying proposals 1–3 is attached as Appendix A. A model statute embodying proposal 4 is attached as Appendix B.

BACKGROUND

The Context for Antitrust Reform

When physicians join together to negotiate with a payer, their conduct often takes one of two forms. In the first situation, physicians in independent medical practice offer their services to managed care plans and other third party payers. They may approach a payer to propose specific reimbursement levels for particular medical services. Physicians affiliated with a particular medical plan may also wish to express their concerns about coverage, utilization, administrative, and financial decisions of the plan that have a direct impact on the practice of medicine. Often, the physicians act through their medical society or other professional group, but in many instances, would like to work directly with managed care plans with which they are affiliated.

In the second situation, independently practicing physicians compete with managed care plans. They may form an entity to market their services jointly to employers or other purchasers of medical services. The physicians offer a variety of services valuable to payers and patients such as utilization review, quality assurance, and joint billing. They also develop a schedule of discounted fees. However, the physicians do not actually merge their practices.

Antitrust officials in the Federal Trade Commission ("FTC") and the Department of Justice ("DOJ") consider negotiations of fees in both contexts to be *per se* violations of the antitrust laws—*i.e.*, activities that must be condemned without any significant analysis of their effects on competition. Accordingly, the agencies have aggressively pursued physicians who have attempted to negotiate fees with payers either through a professional organization[4] or through a joint marketing venture.[5] Speeches and public statements by antitrust officials have reinforced the message that physicians who approach payers collectively will face serious antitrust risks.[6]

Ironically, during the same period, the FTC and DOJ have shown a highly permissive attitude toward the conduct of third party payers. This is so even though some payers represent powerful corporate entities with significant market power.[7] Indeed, the leniency of these agencies towards payer conduct has not been limited

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[4] *See, e.g., United States* v. *Alston, supra,* 974 F.2d 1206; *United States* v. *Burgstiner,* 1991–1 Trade Cas. (CCH) ¶ 69,422 (1991) (consent order); *United States* v. *Massachusetts Allergy Society,* 1992 Trade Cas. (CCH) ¶ 69,846 (1992) (consent order).

[5] *See, e.g., Southbank IPA. Inc.,* FTC Docket No. C–3355, 57 Fed. Reg. 2913 (January 24, 1992) (consent order); *Preferred Physicians. Inc.,* 110 F.T.C. 157 (1988) (consent order); *United States* v. *Greater Bridgeport IPA, Inc.,* 7 Trade Reg. Rep. (CCH) ¶ 50,741 (1992) (proposed consent order).

[6] *See, e.g.,* "Health Care Cost Containment and Competition," Address by James F. Rill, Assistant Attorney General, Antitrust Division, Dept. of Justice (April 23, 1991); "Antitrust Enforcement in the Health Care Field: A Report from the Department of Justice," Address by Robert E. Bloch, Chief, Professions and Intellectual Property Section, Antitrust Division, Dept. of Justice (Feb. 15, 1991).

[7] *See* M. Pauly, *Competition in Health Insurance Markets,* 51 Law & Contemp. Probs. 237, 242–43 (1989); *Kartell* v. *Blue Shield of Massachusetts,* 749 F.2d 922, 924 (1st Cir. 1954) (Blue Shield provides health insurance coverage for 744 of Massachusetts residents who privately insure against health costs).

to the unilateral activities of a single payer. The FTC and DOJ have also declined to take action against coalitions of health care purchasers who join together for the express purpose of exercising bargaining leverage in negotiations with individual providers.[8]

The result of these enforcement policies is a grossly uneven playing field in the market for medical services. Physicians have been deterred from engaging in conduct that promotes competition and helps patients. At the same time, there is a near complete absence of antitrust supervision of the practices of third party payers.

Instead of protecting competition in health care, federal antitrust policy has had the perverse effect of tilting the competitive balance in favor of large payers and against independently practicing physicians and their patients. The need for change is made even more acute by the growing consensus that the health care system is itself in critical need of repair. It is often said that the antitrust laws are designed to serve as a "consumer welfare prescription."[9] If that is so, the FTC and the DOJ are prescribing the wrong medicine.

SPECIFIC PROPOSALS

I. The antitrust laws should not prohibit physicians from agreeing on reimbursement levels to propose to a third party payer

The AMA's first proposal is that physicians should be permitted to agree on reimbursement levels to suggest to a third party payer. Physicians have long sought to make their views known on reimbursement matters to third party payers. Among the topics that physicians address in communications with payers are whether reimbursement levels are appropriate, whether a particular service should be covered, and whether particular administrative practices of the payer are sound. Often, the physicians speak through their medical society, which has the resources and expertise on medical and economic issues to develop and present useful data.

a.

Absent a boycott or threat of boycott by the physicians, physician input on reimbursement issues may have substantial procompetitive benefits. It is axiomatic that health care markets suffer from a chronic deficiency of information.[10] The information that patients and payers most need is frequently within the collective expertise of the medical profession. For example, whether an insurer should pay for a particular medical service may depend on whether the service is deemed "medically necessary" within the terms of the insurer's policy.[11] That issue cannot be meaningfully addressed without the input of practicing physicians.

Payers also need information from practicing physicians regarding the appropriateness of fee levels. In most payment plans, the payer must determine fee levels for thousands of medical services.[12] To do so, the payer must consider not only the historical charges of individual physicians, but also the costs that physicians incur in providing each type of service. In order to determine whether the benefits of a service justify its costs, the payer must also evaluate clinical information regarding the efficacy of particular services. Physicians acting through their medical societies or other groups are uniquely capable of contributing information that may assist payers to make these determinations.[13]

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[8] *See* "Group Buying and Antitrust," Address by Kevin J. Arquit, Director, Bureau of Competition, Federal Trade Commission (April 2, 1992); "Health Care and Antitrust Enforcement: The Buyer's Eye View," Address by Charles F. Rule, Assistant Attorney General, Antitrust Division, U.S. Department of Justice (February 28, 1989).

[9] *Reiter* v. *Sonotone Corp.*, 442 U.S. 330, 343 (1979) (quoting R. Bork, *The Antitrust Paradox* 66 (1978)).

[10] *See, e.g.*, K. Arrow, *Uncertainty and the Welfare Economics of Medicare Care*, 53 Am. Econ. Rev. 941 (1970); M. Pauly, *Is Medical Care Different?*, in *Competition in the Health Care Sector: Past Present and Future* 11 (W. Greenburg ed. 1978).

[11] *See generally* Annot., *What Services. Equipment, or Supplies are "Medically Necessary" for Purposes of Coverage Under Medical Insurance*, 75 A.L.R. 4th 763 (1990). Moreover, an insurer's decision whether to provide coverage may have liability implications for the treating physician. *See, e.g., Wickline* v. *State of California*, 183 Cal. App. 1064, 228 Cal. Rptr. 661 (Cal. App. 1986).

[12] *See Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 139 (1982) (Rehnquist, J., dissenting on other grounds) ("Insurance claimants seek reimbursement for virtually every form of medical treatment and care, and determining the reasonableness and necessity of such expenses requires the expertise of a practicing physician.").

[13] The development of Medicare's new "resource-based relative value scale" ("RBRVS") system of payment illustrates the contributions that physicians, acting collectively, can make on reimbursement issues. In developing the RBRVS, Medicare officials and Congress recognized that physician involvement was essential. *See* 42 U.S.C. §1395w–4(c)(2)(A)(ii). The Department of

Continued

By approaching a payer collectively, through a medical society or other professional group, physicians can achieve economies in the production and dissemination of information that would otherwise be unattainable. Medical societies often possess both the resources and the expertise to gather and meaningfully analyze fee-related data. By contrast, an individual physician does not have the time or resources to develop a picture of conditions across an entire segment of the profession. Although it is possible for each payer to collect such information from individual physicians, such an approach is costly and time-consuming and may compromise the accuracy of the data received. It is far more efficient for payers to collect this information from professional groups.[14]

Suppose, for example, that a new medical procedure is developed to examine cells for cervical cancer. When the test first comes into use, payers may lack information concerning the circumstances in which the test should be performed, the amount of time that it takes, and the costs that it involves. As a result, a payer may establish a fee that does not adequately take these considerations into account. Over time, even if the physicians do not collectively make their views known, the payer may learn through trial and error how to adjust its fees. But trial and error is costly, both in human and economic terms. While the payer is learning the market, some patients may fail to receive timely testing.

Efficiency is promoted when physicians who perform the test can join together and provide the payer with information about the test, its costs and benefits, and the fee that the physicians view as reasonable. If the physicians make a compelling presentation, fees will be adjusted in their favor. If the payer is not persuaded, fees will stay the same or be reduced. Competition will not be harmed in either event.[15] Under current policy, however, physicians cannot approach the payer collectively to make a fee proposal without significant antitrust risk.

In this regard, it should be noted that an agreement by physicians on a fee proposal does not raise the same potential for harm to competition that ordinarily arises when competitors reach an agreement related to price. Unlike typical sellers, physicians generally have little or no direct control over the amounts they are paid. Particularly in the managed care context, they are "price takers" rather than "price makers." Thus, when a group of physicians agrees on a fee proposal to make to a payer, the agreement has no direct economic effect: It influences prices only to the extent that the payer chooses to adopt the proposal. Competition is not harmed unless the physicians engage in a boycott or other coercive conduct that effectively forces the payer to raise its fees.[16]

To be sure, there is the potential for anticompetitive behavior when physicians join together to negotiate fees with a payer. The physicians must continue to make individual decisions regarding participation in the payer's plan. A mass campaign of departicipation designed to coerce a payer to increase its fees would be properly treated as an unlawful group boycott. But boycotts can be detected and sanctioned without forbidding every collective effort by physicians to make their views on fee-related issues known to a payer.

In theory, there is also some risk that an agreement among physicians to propose a reimbursement level to a payer could "spill over" into an agreement on the fees that the physicians charge in their individual medical practices. But the risk is remote. Such a spill-over effect has never been documented in any litigated case or economic study.[17] Moreover, with the growing prevalence of managed care, it is becoming increasingly unlikely that such a spill-over could occur. A physician who is

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Health and Human Services ("HHS") therefore convened consulting panels of physicians in each medical specialty to provide necessary clinical and reimbursement-related information. Although the RBRVS went into effect a year ago, HHS is continuing to consult with professional organizations in an effort to develop a workable payment system. Moreover, HHS officials have indicated that they will continue to do so in the future.

[14] *See* F. Easterbrook, *Maximum Price Fixing,* 48 U. Chi. L. Rev. 886, 898 (1981).

[15] It should go without saying that a fee increase that results from purchaser's unilateral, informed decision is not anticompetitive. *See* R. Posner, *Information and Antitrust,* 67 Geo. L.J. 1187 (1989).

[16] *See Schachar* v. *American Academy of Ophthalmoloay,* 870 F.2d 397, 400 (7th Cir. 1989) (when medical society "provides information . . . but does not constrain others to follow its recommendations, it does not violate the antitrust laws."); *Virginia Academy of Clinical Psychologists* v. *Blue Shield of Virginia,* 624 F.2d 476, 483 (4th Cir. 1980) (not illegal for medical society "to make recommendations aimed at persuading Blue Shield to adopt its proposal and use its services, absent some form of coercion.").

[17] The FTC has noted the possibility of spill-over as a theoretical matter only. *See American Society of Internal Medicine,* 105 F.T.C. 505 (1985) (advisory opinion) (stating that physician agreement on relative value scale might spill over into physicians' individual medical practices).

merely a "price taker" can propose, but has no power to implement, an agreed-upon fee level.

b.

Despite the strong potential for procompetitive benefits from physician negotiations with third party payers, the FTC and DOJ have viewed nearly all collective presentations to payers relating to reimbursement as inherently suspect. The most recent example is the price fixing prosecution of three Tucson dentists and their professional corporations in *United States* v. Alston.[18]

Alston involved approximately fifty dentists in Tucson, Arizona who agreed on a revised schedule of "co-payments" to propose to four prepaid dental plans.[19] The dentists also sent identical letters to the plans presenting their proposed schedule and the reasons why it should be adopted. Subsequently, the plans raised their co-payments to the level proposed by the dentists. The DOJ prosecuted the dentists on the theory that they had fixed prices by agreeing on a specific increased fee level to propose to the plans. Notably, the DOJ did not allege a boycott: It was undisputed that the dentists had continued to provide services to plan patients throughout the period of negotiations.

In its opinion, the Ninth Circuit makes several important observations about provider-payer negotiations. The court notes that health care providers face an "unusual situation that may legitimate certain collective actions."[20] In particular, providers must deal with payers who "act as bargaining agents" for large groups of consumers and who "use the clout of their consumer base to drive down health care service fees."[21] Further, fees are often set not by the provider but by the payer, according to uniform fee schedules. The court found that:

> In light of these departures from a normal competitive market, individual health care providers are entitled to take some joint action (short of price fixing or group boycott) to level the bargaining imbalance created by the plans and provide meaningful input into the setting of the fee schedules. Thus health care providers might pool cost data in justifying a request for an increased fee schedule. Providers might also band together to negotiate various other aspects of their relationship with the plans such as payment procedures, the type of documentation they must provide, the method of referring patients and the mechanism for adjusting disputes. Such concerted actions, which would not implicate the per se rule, must be carefully distinguished from efforts to dictate terms by explicit or implicit threats of mass withdrawals from the plans.[22]

The Ninth's Circuit's opinion does not resolve the question whether the dentists' conduct violated the antitrust laws.[23] Nevertheless, its analysis points the way to a correct resolution of the antitrust issue. Contrary to the position urged upon the court by the DOJ, the opinion expressly endorses the View that health care providers may "band together to negotiate" fees and other aspects of their relationship with payers. In particular, providers may submit "a request for an increased fee level" and may join together to "provide meaningful input into the setting of the fee schedules."[24]

Alston demonstrates the need for reconsideration of the application of the antitrust laws to physician-payer negotiations. Physicians and other health care providers should not be exposed to the "crushing consequences" of a criminal prosecution for engaging in conduct that is arguably procompetitive.[25] Criminal sanctions should

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[18] 974 F.2d 1206 (9th Cir. 1992).

[19] The plans paid participating dentists a capitation fee for each patient, and permitted the dentists to charge an additional co-payment for certain more complex procedures such as root canals. *Id.* at 1207. "The plans, not the dentists, determine[d] both fee amounts." *Id.*

[20] *Id.* at 1214.

[21] *Id.*

[22] *Id.* (citation omitted).

[23] The appellate court found that there was a factual dispute as to whether the dentists believed that the plans wanted them to submit a fee proposal. *Id.* at 1208 n.2, 1213. Accordingly, the case was remanded to the district court for a possible new trial.

[24] As additional examples of conduct that "would escape the per se rule and might be perfectly legal under the rule of reason," the Ninth Circuit cited: "dentists commiserating over the low fee schedules; or impugning the motivations or integrity of the plans; even sabre-rattling about economic retribution at some indefinite time in the future if their grievances remain unaddressed." *Id.* at 1214. The court further noted that "[s]ome such activity . . . would even be constitutionally protected." *Id.*

[25] *Id.*

be reserved for conduct that is clearly anticompetitive and that a defendant knows is wrong.[26] Under that test, the actions of the Tucson dentists do not warrant prosecution. Theirs was an open and overt campaign to persuade the plans that co-payment fees were inadequate. The plans acted to raise fees because the dentists made their case.[27]

The AMA calls upon antitrust officials to issue a clear statement that physicians are free to approach payers collectively in order to provide input on fees and other payment-related issues, absent a boycott or threat of boycott. The AMA will also seek legislation along the lines of the Physician-Health Plan Negotiations Act (Appendix A) to establish a "safe harbor" for physicians who present their views collectively to payers without engaging in price fixing or a boycott. Otherwise, health care providers will be deterred from engaging in useful and potentially procompetitive activities.

II. The antitrust laws should not prohibit physicians from forming joint marketing networks to negotiate direct contracts with purchasers of medical services

The AMA's second proposal is that physicians should be permitted to form joint marketing networks for the purpose of negotiating contracts with employers and other purchasers of medical services. Under current enforcement policy, physicians who form such a network may not establish a fee schedule for the network unless they accept pre-paid, capitated fees or otherwise share an insurance-type risk. This policy is inhibiting the formation and operation of procompetitive ventures that can lower the cost and increase the quality of health care.

a.

The majority of physicians in the United States today are self-employed and practice in small, independent medical offices.[28] In recent years, many independent physicians have been looking for ways to maintain or increase their patient base without altering the basic structure of their practice. One approach has been to form an independent practice association, or "IPA."

An IPA is an organization of independently practicing physicians who act as a single entity for purposes of obtaining contracts with purchasers of medical services. By acting together, the physicians in an IPA can offer a package of services that none of them could offer individually. In particular, an IPA can offer a full range of medical specialty services, widespread geographic coverage, and a high level of physician capacity. In addition, an IPA often provides centralized billing and administration, quality assurance, utilization review, practice profiling, and other services. Sometimes, the IPA works together with a hospital to offer an even broader package of services.[29]

The IPA structure is particularly attractive to self-insured employers who are looking for a network of physicians to provide care to their employees.[30] By contracting directly with the IPA—rather than through an insurance company or HMO—the employer can significantly reduce its costs in two respects. First, the employer reduces its search costs by obtaining access to a network of high quality, discounted-fee providers—without having to assemble its own panel. Second, the employer reduces costs by eliminating the insurer or HMO "middleman."

In order for the IPA to function, however, it must be able to establish prices for the services of its members. This can be done in a number of ways. One option is for the physicians to agree to accept a fixed, prepaid amount and to function, in effect, as an HMO. Alternatively, the physicians may prefer to provide services on a fee-for-service basis under a schedule of discounted fees. Under either approach, the expectation of increased patient volume enables the physicians to offer lower fees than they might otherwise offer.

The physicians' agreement on fees for the IPA may be price fixing in the literal sense, but it is not the type of price fixing that the antitrust laws are designed to

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[26] *See United States* v. *United States Gypsum Co.*, 438 U.S. 422, 442 (1978) (criminal sanctions under Sherman Act should be limited to "conscious and calculated wrongdoing" and should not be used to "regulate business practices regardless of the intent with which they were undertaken.").

[27] As the Ninth Circuit noted, the co-payment levels in Tucson had not been increased in ten years. 974 F.2d at 1207. Through the negotiations, the dentists obtained an increase to the level permitted by plans in Phoenix.

[28] American Medical Association, Center for Health Policy Research, *Physician Marketplace Statistics—1991* 109–10.

[29] *See e.g.*, J. Johnsson, "Direct Contracting: Employers Look to Hospital-Physician Partnerships to Control Costs," *Hospitals* (Feb. 20, 1992), at 56.

[30] *See, e.g.*, P. Kenkel, "Taking the Direct Approach," *Modern Healthcare* (March 16, 1992), at 45.

prevent. The establishment of a price is essential to the marketing of the IPA.[31] As long as the IPA is not so large as to possess market power, the physicians will have every incentive to reduce their fees so that payers will want to contract with them. If the physicians do not lower their fees, payers will seek contracts from other physicians or physician groups.

Only if the physicians participating in the IPA collectively possess market power could the IPA be used as a vehicle for suppressing competition and driving up fees. Without market power, an IPA that fails to offer attractive fees will simply not stay in business.

b.

Both the FTC and the DOJ have spoken out strongly against the formation of what they refer to as "sham IPAs."[32] The agencies place in this category any IPA that establishes fees but that does not involve substantial economic "integration" among the physician members. An essential feature of integration, in the view of antitrust, officials, is direct financial risk-sharing among members of the IPA. Absent such integration, the FTC and DOJ consider joint pricing by the physician members of the IPA to be *per se* illegal.

For example, in the FTC's *Southbank* case,[33] the Commission obtained a consent decree against an IPA formed by several obstetrician-gynecologists in the Jacksonville, Florida area. The IPA had collectively marketed its services to payers based on a discounted fee for service payment schedule. It also offered ancillary services such as quality assurance and utilization review. The Commission's consent decree required the dissolution of the IPA, on the theory that the physicians' establishment of a fee Schedule constituted price fixing.

In addition, the consent decree prohibited the individual physicians from engaging in other joint arrangements unless those arrangements qualified as an "integrated joint venture." The consent decree defined an "integrated joint venture" as an arrangement in which:

> physicians who would otherwise be competitors pool their capital to finance the venture, by themselves or together with others, *and share substantial risk of adverse financial results caused by unexpectedly high utilization or costs of health care services.*[34]

The agencies have also used this definition in other enforcement proceedings and in informal statements of policy.[35]

The *Southbank* definition of "integrated joint venture" deters the formation of IPAs and other procompetitive physician joint ventures. Under the *Southbank* definition, an IPA will not qualify as an "integrated joint venture" if it accepts payment on a fee-for-service basis. Instead, the IPA must agree to accept fixed, capitated fees—thus becoming, in effect, an HMO that both provides services and insures against excess utilization. In order to calculate capitated fees, the IPA must have access to actuarial data used by insurance companies. But physicians do not ordinarily have access to this sort of information, and acquiring it can be costly.

The most significant problem with the *Southbank* approach is that it fails to recognize that IPAs can offer significant efficiencies even without financial risk-sharing. Efficiencies are gained from joint billing, utilization review, quality assurance, adherence to practice guidelines, and the like. Further, by including physicians from throughout a payer's service area, an IPA can offer payers a "new product" that no individual physician could offer—*i.e.*, a panel of physicians available to provide services to all of the payer's insureds or enrollees.[36] Indeed, a former chief of the Antitrust Division has recognized the "substantial procompetitive benefits" that may be achieved through "integration that falls short of financial participation and sharing of risks:"

> For example, integrative efficiencies can be realized through an agreement among physicians to give up some of their freedom in setting the terms of billing and treatment in order to reduce transaction costs and to offer discount fee levels. In addition, provider-controlled PPOs may jointly market

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[31] *See Broadcast Music Inc.* v. *Columbia Broadcasting System*, 441 U.S. 1 (1979) ("BMI").

[32] *See, e.g.*, "Antitrust Perspectives On Joint Ventures Among Health Care Providers," Address by Mark Horoschak, Assistant Director, Bureau of Competition, Federal Trade Commission (August 11, 1992).

[33] *Southbank IPA, Inc.*, FTC Docket No. C–3355, 57 Fed. Reg. 2913 (January 24, 1992) (consent order).

[34] *Id.* at 2914 (emphasis added).

[35] *See, e.g., Preferred Physicians. Inc.*, 110 F.T.C. 157 (1988) (consent order).

[36] *Cf. BMI, supra*, 441 U.S. at 21–23.

their venture to insurers or small employers unable to organize their own panels. In both cases, PPOs can generate procompetitive benefits despite the fact that financial risk is not shared.[37]

Contrary to the assertions of antitrust officials, the *Southbank* approach is not required by the Supreme Court's decision in *Arizona* v. *Maricopa County Medical Society*.[38] *Maricopa* involved the development of a fee schedule by a medical foundation consisting of 70% of the physicians in the Phoenix area. The Court specifically found that the foundation had "substantial power in the market for medical services."[39] By contrast, the agencies' current approach condemns any "unintegrated" venture in which physicians agree on a fee schedule, regardless of the venture's size.[40]

In considering the lawfulness of physician joint ventures such as IPAs, the FTC and DOJ should focus on the size of the IPA and the nature of the efficiencies that it offers, rather than demanding the sharing of an insurance-type risk. Without market power, an IPA cannot coerce any payer into dealing with it and therefore cannot harm competition. Further, an IPA that is limited in size has a strong incentive to exercise selectivity—*i.e.*, to choose the highest quality physicians that it can obtain at the desired fee level. The physicians in the IPA therefore share incentives to control utilization and costs, even without acting as insurers.

An IPA is a "sham" only if it offers no significant efficiencies. But efficiencies can be gained from joint activities other than direct financial risk-sharing through the acceptance of fixed, capitated fees. Indeed, physicians who commit to a joint program of cost containment do share risk, even if they are paid on a fee-for-service basis. For the venture to be successful, the physicians must each provide services on a cost-effective basis. A failure to do so will reflect poorly not only on the venture, but also on the individual physicians.

Once again, this issue could be addressed by an unequivocal public statement by antitrust enforcement agencies that they will not take action against physicians who are attempting to compete by creating procompetitive joint ventures, regardless of whether direct financial risk-sharing is involved. However, given the uncertainty engendered by previous enforcement actions, the AMA believes that legislative action may be necessary.

Specifically, the AMA is proposing in the legislation set forth in Appendix A that physician networks that meet appropriate qualifications should be free to establish fee schedules in order to market their services to employers and other third party payers. To qualify for such treatment, the network should include no more than 20% of the total number of physicians, or of the physicians from a particular specialty, in a relevant geographic area.[41] In addition, the network should have at least three of the following efficiency-enhancing characteristics:

- the network follows a quality assurance program that regularly reviews the services provided by IPA members;
- network members adhere to a defined set of practice parameters;

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[37] "Antitrust in the Health Care Field: Distinguishing Resistance from Adaptation," Address by Charles F. Rule, Assistant Attorney General, Antitrust Division, Department of Justice (March 11, 1988), at 12–13.

[38] 457 U.S. 332 (1982).

[39] *Id.* at 354 n.29.

[40] To be sure, the Court in *Maricopa* did use language similar to the *Southbank* definition of "integrated joint venture" at one point in its opinion. Specifically, the Court distinguished a medical foundation established by "hundreds of competing doctors" from "partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit." 457 U.S. at 356. But this *dictum* does not require financial risksharing as a prerequisite to legality. Rather, it merely sets forth one example of a type of venture that would plainly be lawful.

It is questionable whether *Maricopa* would be decided the same way today. *Maricopa* was decided by a sharply divided (4–3) Court, with Justices Blackmun and O'Connor not participating. Justice Powell wrote a strong dissent arguing that the physicians' agreement on a fee schedule was comparable to the agreement on prices upheld in *BMI*. Interestingly, the Ninth Circuit panel that the Supreme Court reversed included Judge, now Justice, Kennedy. *See* 643 F.2d 553.

[41] In this regard, the draft legislation provides that the percentage of physician participation in a health plan should be determined by including in the numerator the number of physicians who participate in the network, and including in the denominator the sum of the total number of physicians participating in each health plan in the market. This method, which Justice Department officials have referred to in speeches, adjusts for the overcounting of market share that otherwise results when—as is often the case—physicians participate in multiple plans. *See* "Antitrust Enforcement Policy and the Treatment of Horizontal Price Restraints: Lessons for the Health Care Industry," Address by James F. Rill, Assistant Attorney General, Antitrust Division, Dept. of Justice, at 10 n.3 (Feb. 15, 1991).

- the network employs practice profiling, outcomes research or similar techniques to evaluate, critique and improve the performance of its members.
- the network is responsible for billing and collecting fees for the services of members;
- network members contribute a pro rata portion of the network's total equity capitalization;
- network members share the risk of overutilization of services, through capitation payments or withholding of a percentage of payments.

Physician networks that meet the 20% rule and satisfy at least three of these criteria should be permitted to engage in joint pricing and negotiations without fear of liability under §1 of the Sherman Act or §5 of the FTC Act. Networks that fall short of the statutory criteria should generally be analyzed under the rule of reason. Only those networks that involve physicians with market power who have engaged in no significant integration of their practices—but who nevertheless agree on prices—should be treated as unlawful *per se.*

III. The antitrust laws should not prohibit physicians from forming negotiating groups of reasonable size to bargain collectively with market dominant payers

The AMA's third proposal is that physicians in a community in which there is a payer or coalition of payers with market power should be permitted to form a negotiating group to bargain collectively with the payer. The AMA proposes that the negotiating group be limited in size to no more than a fixed percentage—for example, 20%—of the physicians in the community or in any specialty.

a.

The issue of buyer-side market power in health care is a timely and important one. Already, in many states, the market for health insurance and other forms of health care financing is dominated by a single large payer such as a Blue Cross and Blue Shield plan.[42] Typically, in addition to a dominant payer, there are many smaller payers such as self-insured health benefits plans offered by employers.

Current proposals for health care reform, if enacted, are likely to result in a significant increase in concentration in health care financing markets. For example, the "single payer" or "Canadian system" approach calls for a single monopsonistic purchaser that procures medical services on behalf of all citizens.[43] Even so-called "managed competition" approaches foster the creation of large purchasing cooperatives and the operation of "relatively few managed care organizations in each geographic area."[44] Although these proposals differ greatly in their particulars, they share the underlying goal of encouraging payers—as the *Alston* court put it in a somewhat different context—to "use the clout of their consumer base to drive down health care service fees."[45]

As a matter of economics, the exercise of monopsony power by large payers or coalitions of payers should cause as much concern as anticompetitive conduct on the part of providers. "[I]t is bedrock economic theory that powerful buyers, whether acting individually, as a monopsonist, or in collusion with other buyers are capable of causing the same economic harm that the antitrust laws are designed to prevent."[46] In the health care context, the exercise of monopsony power by large payers

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[42] M. Pauly, *Competition in Health Insurance Markets,* 51 Law & Contemp. Prob. 237, 242–43 (1988).

[43] *See, e.g.,* D. Himmelstein & S. Woolhandler, *A National Health Program for the United States: A Physicians' Proposal,* 320 New Eng. J. Med. 102 (1989).

[44] A. Enthoven & R. Kronick, *Universal Health Insurance Through Incentives Reform,* 265 J.A.M.A. 2532 (1991); A. Enthoven & R. Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy,* 320 New Eng. J. Med. 29 (1989). *See generally* J. Gaffney, S. Browning, & E. Hirshfeld, *Proposals to Reform the U.S. Health Care System: A Critical Review,* 1 Health Econ. 181 (1992).

[45] *United States* v. *Alston, supra,* 974 F.2d at 1214; *cf.* "The Role of Antitrust in Improving and Reforming the Health Care System," Address by Kevin J. Arquit, Director, Bureau of Competition, Federal Trade Commission (October 15, 1992), at 4 ("The core concept of the system-wide reforms being proposed in the current debate on health care costs . . . is some form of managed care, relying in part on the purchasing power of prepaid health plans to negotiate aggressively for lower prices.").

[46] R. Blair & J. Harrison, *Cooperative Buying, Monopsony Power, and Antitrust Policy,* 86 Northwestern Univ. L. Rev. 331, 331 (1992); *see Vogel* v. *American Society of Appraisers,* 744 F.2d 598, 601 (7th Cir. 1984) (Posner, J.) ("[m]onopoly and monopsony are symmetrical distortions of competition from an economic standpoint."); *see also* H. Hovencamp, *Economics and Federal Antitrust Law,* §1.2, at 17 (1985) ("monopsony can impose social costs on society similar to those caused by monopoly"); M. Pauly, *Monopsony Power in Health Insurance: Thinking*

Continued

can be expected to result in deteriorations of quality and access, including "long waits, a slow rate of technical progress, and contrived shortages of useful care."[47]

To date, however, antitrust officials have taken a benign view of the monopsony power exercised by large third party payers. Indeed, they have sometimes suggested that buyer-side purchasing power in health care may be desirable because it drives prices down. This position represents "nothing less than a frontal assault on the basic policy of the Sherman Act."[48] The antitrust laws embody the principle that competition alone must be relied upon to determine what is an appropriate price.

Current antitrust enforcement policy is therefore both discriminatory to physicians and inconsistent on its own terms. More importantly, however, this policy stands as an obstacle to the development of a rational and just system of health care.

b.

In markets in which a payer or coalition of payers acquires a dominant market share, the exercise of some countervailing strength by physicians is not anticompetitive and should not subject the physicians to antitrust prosecution. The AMA is therefore proposing that physicians faced with dominant payers (*e.g.*, 35% or greater market share) should be permitted to form negotiating groups of reasonable size (*e.g.*, 20% of the physicians in the community or in any specialty) to bargain collectively with the dominant payer. A payer should be treated as a dominant payer if it covers at least 35% of the individuals who are covered by private health insurance in any relevant geographic market.[49]

The exercise of countervailing power by physicians in negotiations with dominant payers should not raise significant competitive concerns. A physician group that lacks market power cannot coerce a monopsonistic payer into raising its fees. If the two sides cannot reach agreement, the payer will simply obtain services from other physicians. And, because of the payer's market strength, the physicians will face a strong incentive to offer attractive terms.

Indeed, allowing physicians to engage in collective conduct is both necessary and appropriate. First, far from undermining competition, such collective conduct should improve the competitive functioning of the system. By providing a "check" on the payer's monopsony power, such conduct will help to counteract the "distortions of competition" that monopsony may otherwise produce.[50] In the health care context, such distortions would include deteriorations in the quality of and access to care.[51]

Physicians acting collectively can combat such distortions by acting as representatives of their patients' interests. In this regard, it is far too simplistic to suppose that payers act as "consumers' surrogates."[52] The interests of payers and patients diverge in significant respects. Payers aim to control utilization and cost. Patients care about costs too, but they also have an intense interest in obtaining medical services of high quality and in maintaining a choice of physicians. Through collective action, physicians can help minimize the harmful effects of monopsony on patients' interests.

Second, by permitting physicians to join together in negotiating groups of reasonable size, significant transactional efficiencies could also be achieved. Large payers could obtain a panel of physicians by negotiating with a few groups, rather than with hundreds of individual physicians. Physician groups would compete vigorously to obtain the large payer's contract. They might also be encouraged to integrate their practices by forming IPAs or other procompetitive joint ventures.

Straight While Standing on Your Head, 6 J. Health Econ. 73, 73 (1987) ("monopsony may have seriously adverse consequences for overall economic efficiency, whatever it does to price and expenditure levels").

[47] M. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemp. Probs. 237, 260 (1989). The monopsony problem has been addressed in a number of antitrust cases. The leading case is *Mandeville Island Farms* v. *American Crystal Sugar Co.*, 334 U.S. 219 (1948). *See also United States* v. *Griffith*, 334 U.S. 100 (1949); *National Macaroni Mfg. Assoc.* v. *FTC*, 345 F.2d 421 (7th Cir. 1965); *United States* v. *Rice Growers Assoc*, 1986–2 Trade Cas,. (CCH) ¶ 67,288 (E.D. Cal. 1986); *United States* v. *V.C. Itoh & Co.*, 1982–83 Trade Cas. (CCH) ¶ 65,010 (W.D. Wash. 1982).

[48] *See, e.g., National Society of Professional Engineers* v. *United-States*, 435 U.S. 679, 695 (1978).

[49] The 35% figure was cited by the Justice Department in a 1986 business review letter that considered the level at which a group purchasing cooperative might be able to exercise monopsony power. *See Gulf Wine & Spirit shippers' Council. Inc.*, B.R.L. 86–7 (response letter).

[50] *Vogel, supra*, 744 F.2d at 601.

[51] M. Pauly, *supra* n. 42, at 260.

[52] K. Arquit, supra n. 44, at 5.

Finally, physicians confronted with large aggregations of purchasing power should—in the words of the *Alston* court—be "entitled to take some joint action" in order to "level the bargaining imbalance."[53] It is simply inequitable to encourage concentration on the purchasing side of medical services transactions, while prohibiting collective bargaining on the providers' side. As one commentator has stated, "good-faith collective bargaining" ought to be "the monopsonist's duty."[54]

In this regard, physicians today face a situation comparable to those historical circumstances in which antitrust reforms have been enacted. Consider, for example, the following passage from the legislative history of the Capper-Volstead Act,[55] a statute that created a partial antitrust exemption for agricultural cooperatives:

> "The farmers are not asking a chance to oppress the public, but insist that they should be given a fair opportunity to meet business conditions as they exist—a condition that is very unfair under the present law. Whenever a farmer seeks to sell his products he meets in the market place the representatives of vast aggregations of organized capital that largely determine the price of his products. Personally he has very little if anything to say about the price. If he seeks to associate himself with his neighbors for the purpose of collectively negotiating for a fair price, he is threatened with prosecution."[56]

Like the farmers in the early part of this century, physicians today compete as individuals or small groups in a highly atomized seller's market. Their services are paid for by "vast aggregations of organized capital"—powerful third party payers who are likely to grow still larger in the context of health care reform. Under current antitrust policy, however, physicians who attempt to join together to bargain collectively with a powerful payer are "threatened with prosecution."

This state of affairs is bad for physicians, bad for patients and bad for the efficient delivery of health care in America. Fairness dictates that physicians dealing with market dominant payers should be permitted to assert some countervailing strength. The legislation attached as Appendix A would achieve this result.

IV. The antitrust laws should not prohibit physicians affiliated with a managed care plan from collectively providing their input on medical review criteria, quality assurance programs, and other financial and administrative decisions of the plan

As noted above, managed care plans are taking aggressive action to control costs. Current legislative proposals envision a system of managed competition in which the power of these plans would be even greater.[57] While cost control is a desirable objective, excessive cost cutting can result in a refusal to pay for medically necessary services or in an unreasonable reduction in the quality of care received by plan enrollees. Either result is, of course, directly contrary to the interests of patients.

The AMA believes that the most effective way of sensitizing managed care plans to the impact on patients of their decisions regarding coverage, medical policies, and reimbursement is to give physicians a voice in those decisions. Physicians are representatives of the interests of patients in quality of and access to care. As such, they provide a unique perspective that can assist managed care plans in formulating and implementing policies. While all decisions must ultimately be made by the plans themselves, physicians affiliated with the plans should be encouraged to provide their collective input on such decisions.

To this end, the AMA is proposing the Managed Care Improvement Act of 1993 (copy attached as Appendix B). The Act would require managed care plans to establish committees of physicians that would advise management on medical review criteria, quality assurance programs, grievance mechanisms, and certain financial and administrative matters. It would also authorize physicians affiliated with a plan to provide their collective input on these and other matters—as long as no boycott was threatened or engaged in.

If physicians are to be encouraged to serve on committees advising managed care plans and otherwise to provide their collective views to such plans, they must be assured of immunity from the antitrust laws where they have acted in good faith.

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[53] 974 F.2d at 1214.

[54] R. Pfizenmayer, *Antitrust Law and Collective Physician Negotiations with Third Parties: The Relative Value Guide Object Lesson,* 7 J. Health Politics, Policy & L. 128, 151 (1982).

[55] 15 U.S.C. §17.

[56] H.R. Rep. No. 24, 67th Cong., 1st Sess. 2 (1921) (quoted in 1 P. Areeda & D. Turner, *Antitrust Law* ¶ 228, at 186 n.34 (1978)).

[57] *See* p. 27, nn. 43–44, *supra.*

Such immunity is necessitated by cases in which well meaning physicians have become embroiled in protracted antitrust litigation for attempting to formulate thoughtful medical policies.[58] It is also necessitated by physician reluctance to engage in any sort of collective conduct as a result of a number of well publicized cases in which physicians have been held liable for such action.[59] Accordingly, the Act includes a provision immunizing from the antitrust laws collective input to managed care plans by physicians affiliated with these plans if the physicians act in good faith and do not threaten a boycott.

The AMA submits that antitrust immunity for physicians in these circumstances is sound policy. Collective presentation of physicians' views to payers, including views on reimbursement matters, does not violate the antitrust laws as long as the presentations are not accompanied by a threat of boycott.[60] Statutory immunity would simply enable physicians to avoid the debilitating costs of plenary antitrust litigation and would thus encourage them to participate in decision-making by managed care plans. Accordingly, the AMA respectfully requests that federal antitrust agencies support the immunity provisions of the Managed Care Improvement Act of 1993.

CONCLUSION

America's health care delivery system stands on the threshold of major change. The AMA supports reforms that will improve the cost-effectiveness of care and that will provide access to care for the uninsured. If these reforms are to work, however, they must be accompanied by modifications in the antitrust laws—or at least in current enforcement policies—to permit a meaningful physician role in negotiations with payers. Such modifications are essential if the antitrust laws are truly to serve as a patient welfare prescription.

APPENDIX A—PHYSICIAN-HEALTH PLAN NEGOTIATIONS ACT

Section 1. *Short Title.* This Act may be cited as the "Physician-Health Plan Negotiations Act of 1993."

Section 2. *Policy and Intent.* It shall be the policy of the United States to encourage the formation of cooperative physician networks for the purpose of contracting for and delivering efficient and high quality medical services. The intent of this Act is to facilitate negotiations by physician networks with health plans such as indemnity health insurance plans, health maintenance organizations, preferred provider organizations, managed care plans, self-insured employee benefit plans, and other third party payment programs. It is the further intent of this Act to encourage input by networks of physicians into the administration, coverage and payment policies of such health plans. This Act shall not be construed as restricting or prohibiting any physician arrangements or activities that are otherwise permissible under the federal antitrust laws or the law of any State.

Section 3. *Collective Development and Presentation of Position Statements.*

(a) Networks of independently practicing physicians that satisfy the criteria set forth in subsection (b) shall be permitted collectively to develop and present position statements to health plans, notwithstanding anything in the antitrust laws or the law of any State to the contrary. Such position statements may include:

1. Cost data in support of a request to modify a health plan's fee schedule;
2. Suggestions as to specific proposed reimbursement levels; and
3. Proposals regarding payment procedures, utilization review, administrative requirements, coverage issues and other aspects of the operations of the health plan.

The physicians may select an agent (such as a consultant, attorney, medical society, or other such person or entity) for purposes of developing and presenting such position statements.

(b) To qualify for the legal protection set forth in subsection (a), physician networks that collectively develop or present position statements shall—

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[58] See, *e.g. Schachar* v. *American Academy of Ophthalmology* 870 F.2d 397 (7th Cir. 1989); *Marresse* v. *American Academy of Orthopaedic Surgeons*, 977 F.2d 585 (7th Cir. 1992) (text in WESTLAW); *Koefoot* v. *American College of Surgeons*, 1987–1 Trade Cases ¶ 67,508 (N.D. Ill. 1986).

[59] *See, e.g., Alston, supra*, 974 F.2d 1206; *Patrick* v. *Burget* 486 U.S. 94 (1988); *Weiss* v. *York Hospital*, 745 F.2d 986 (3d Cir. 1984).

[60] *Michigan State Medical Society*, 101 F.T.C. 191 (1983).

1. Permit any individual physician in the network to negotiate and enter into individual arrangements with any health plan (including the plan to which a position statement is submitted);

2. Permit any individual physician in the network to enter into arrangements with other physician networks for purposes of negotiating arrangements with any health plan;

3. Not exchange information among independently practicing physicians in the network concerning their usual charges, except on an aggregate or composite basis that does not reveal the charges of any individual physician; and

4. Not boycott or threaten a boycott of health plans that do not accept the proposals made by the physicians.

Section 4. *Negotiations with Dominant Health Plans.*

(a) Physicians shall be permitted to form one or more Dominant Health Plan Negotiating Networks for purposes of negotiating and entering into contracts with a health plan that has market dominance. A health plan shall be found to have market dominance if the plan covers at least thirty five percent (35%) of the individuals who are covered by private health insurance in any relevant geographic market.

(b) Dominant Health Plan Negotiating Networks will be subject to the following restrictions:

1. The network shall include no more than twenty percent (20%) of the physicians and no more than twenty percent (20%) of the specialists in the relevant geographic market. Notwithstanding the foregoing limitation, the network may include at least two specialists or groups in each specialty in a relevant geographic market, provided that the network includes physicians from at least three specialties.

2. The network shall limit its activities to negotiations with dominant health plans.

3. Physicians participating in the network shall not exchange information concerning their usual charges or any other charges unrelated to the dominant health plan with which the network is negotiating, except on an aggregate or composite basis that does not reveal the charges of any individual physician; and

4. Physicians participating in the network shall be free to adopt whatever arrangements they may desire with non-dominant health plans.

Section 5. *Qualified Independent Practice Networks.*

(a) Physicians may form Qualified Independent Practice Networks ("QIPNs") in accordance with the requirements set forth herein. Any QIPN which satisfies the conditions set forth herein, together with all of its members, shall be conclusively deemed to be a single entity for antitrust purposes. Neither the formation of, nor the activities of, a qualifying QIPN and its members shall be found to be a contract, combination or conspiracy in restraint of trade under Section 1 of the Sherman Act or an unfair method of competition under §5 of the Federal Trade Commission Act.

(b) In order to qualify as a QIPN, a physician network must satisfy the following:

1. The total number of physicians participating in the network shall not exceed twenty percent (20%) of the physicians in the relevant geographic market;

2. The total number of physicians from a particular specialty participating in the network shall not exceed twenty percent (20%) of the specialists in the relevant geographic market, except that the network may include at least two specialists or groups in each specialty;

3. The network shall either include or have entered into arrangements with physicians from at least three specialties;

4. Any network that is not a party to a service contract with at least one health plan for a period of at least one hundred eighty consecutive days shall be terminated;

5. The network shall not enter into any arrangement with any health plan that limits the ability of the network to contract with any competing health plans unless the network represents fewer than ten percent (10%) of the physicians and fewer than ten percent (10%) of the members of each specialty in the relevant geographic market;

6. The network must file an application with the Secretary showing the organizational structure of the network, the initial members of the network, and compliance with each of the requirements of this section.

(c) In order to be qualified under this section, a physician network must satisfy at least three of the following criteria:

1. The network will adopt practice parameters that will be followed by its members in providing services;

2. The network will adopt and follow a quality assurance ("QA") program that regularly reviews all of the services provided by members of the network;

3. Each of the members of the network will contribute a pro rata portion of the total equity capitalization of the QIPN;

4. The network will be responsible for billing and collecting fees for the services of the members of the network;

5. The members of the network, through capitation payments, risk sharing withholds, or other such mechanisms, will share the risk of overutilization of services;

6. The network will employ practice profiling, outcomes research or similar techniques to evaluate, critique and improve the performance of each of the members of the network.

(d) For purposes of subsections (b) and (c), in determining the percentage of physicians in a relevant geographic market who participate in a physician network, the numerator shall consist of the number of physicians who participate in the network and the denominator shall consist of the sum of the total numbers of physicians participating in each health plan in the relevant geographic market (so that in a market in which all the physicians participate in four health plans, each plan would represent 25% of the physicians in the market). In determining the percentage of physicians of a particular specialty in a relevant geographic market who participate in a physician network, the numerator shall consist of the number of physicians in that specialty who participate in the network and the denominator shall consist of the sum of the total numbers of physicians in that specialty participating in each health plan in the relevant geographic market.

(e) By January 1, 1994, the Secretary shall establish application forms for QIPNs which will enable applicants to demonstrate compliance with each of the requirements set forth herein. Such applications shall be filed with the Secretary at least thirty days prior to commencing operations and every five years thereafter. The Secretary shall have thirty days following its receipt of an application to determine whether the applicant complies with each of the requirements of this section. If the Secretary determines that an applicant does not meet the qualifications of this section, the Secretary shall inform the applicant in writing within thirty days of the date of the application of the specific reasons why the applicant does not comply with this section. If the Secretary does not inform the applicant of its rejection of the application within thirty days, the applicant shall be conclusively deemed to qualify as a QIPN under this section.

Section 6. *Other Physician Networks.* The Secretary shall, by January 1, 1994, promulgate regulations establishing a process whereby physician networks other than QIPNs may apply to the Secretary for a finding that the network's formation and operations shall be conclusively deemed lawful under the antitrust laws. The regulations shall specify criteria that the Secretary shall consider prior to taking action on such applications. Such regulations shall be promulgated in accordance with the federal Negotiated Rulemaking Act of 1990, 5 U.S.C. §581 *et seq.* The Secretary shall include representatives of national physician organizations in the negotiated rulemaking proceedings.

Section 7. *Definitions.* Specific terms in this Act shall be defined as follows:

(a) *Health Plan.* "Health plan" shall mean any indemnity health insurance plan, health maintenance organization, preferred provider organization, managed care plan, self-insured employee benefit plan, or other third party payment program that provides reimbursement on behalf of persons covered by the plan for the expense of obtaining health care services or that directly provides health care services in return for premiums paid on behalf of covered individuals.

(b) *Specialty.* "Specialty" shall mean one of the following areas of medical practice: Allergy and Immunology, Anesthesiology, Colon and Rectal Surgery, Dermatology, Emergency Medicine, Family practice, Internal Medicine, Neurological Surgery, Neurology, Nuclear Medicine, Obstetrics-Gynecology, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Pathology, Pediatrics, Physical Medicine and Rehabilitation, Plastic Surgery, Preventive Medicine, Psychiatry, Radiology, Surgery, Thoracic Surgery, and Urology.

(c) *Specialist.* "Specialist" shall mean any physician licensed by a State to practice medicine who is Board-certified or Board-eligible in one or more specialties.

(d) *Secretary.* "Secretary" shall mean the Secretary of the United States Department of Health and Human Services.

Section 8. *Reglations.* The Secretary may promulgate regulations to implement the requirements of this Act. All such regulations shall be promulgated in accord-

ance with the federal Negotiated Rulemaking Act of 1990, 5 U.S.C. §581 et. seq. The Secretary shall include representatives of national physician organizations in the negotiated rulemaking proceedings.

Section 9. *Preemption.* The provisions of this Act shall supersede any and all federal and state laws, including antitrust and trade regulation laws, that might restrict, impose liability for, or otherwise limit physicians, physician networks, Dominant Health plan Negotiating Networks, or QIPNs from operating in accordance with this Act and any regulations promulgated hereunder.

APPENDIX B.—MANAGED CARE IMPROVEMENT ACT OF 1993

Section 1. *Short Title.*

This Act may be cited as the "Managed Care Improvement Act of 1993."

Section 2. *Policy.*

It shall be the policy of the United States to:

(A) require Managed Care Plans to establish committees through which physicians who contract with such Plans may provide advice and recommendations with respect to the Plans' medical review criteria, quality assurance programs, grievance mechanisms, and certain financial and administrative matters;

(B) protect from retaliation physicians who in good faith provide such advice and recommendations to Plans; and

(C) immunize from antitrust liability physicians who participate in good faith in various collective activities related to the purposes of this Act.

Section 3. *Definitions.*

(A) *Affiliated With.* The term "affiliated with" means under agreement, either by written contract or otherwise, to provide services to participants in a Managed Care Plan.

(B) *Managed Care.* The term "managed care" means the systems or techniques generally used by public or private third-party payers or their agents to affect access to and control payment for health care services.

(C) *Managed Care Plan.* The term "Managed Care Plan" or "Plan" means any public or private organization that utilizes managed care systems or techniques. This term includes, but is not limited to, health maintenance organizations and preferred provider organizations. It does not include hospitals.

(D) *Participant.* The term "participant" means any individual for whom a Plan is responsible for providing health care or health care coverage.

Section 4. *Committees.*

(A) Establishment of Committees.

Every Managed Care Plan affecting interstate commerce shall establish, in addition to any other committee that the Plan may establish, (1) a Medical Review Committee, (2) a Quality Assurance Committee, (3) a Grievance Committee, and (4) a Financial and Administrative Matters Committee.

(B) Purpose and Function of Committees.

Each Committee established under subsection (A) of this Section shall be consulted by, and shall advise, the Managed Care Plan on the issues for which it has responsibility under subsection (C) of this Section. The Plan shall take into account any advice or recommendations provided by such Committee. If the Plan rejects or substantially modifies any advice or recommendation provided by a Committee, a representative of the Plan shall meet with the Chair of the Committee or other representative designated by the Committee and shall provide a specific explanation as to why the Plan rejected the advice or recommendation of the Committee.

(C) Responsibilities of Committees.

(i) The Medical Review Committee shall be responsible for periodically reviewing and making recommendations to the Plan regarding the services that the Plan provides or covers, any restrictions that the Plan imposes on the availability or utilization of such services, the eligibility of a Plan participant for a specific service if a question arises about such eligibility, and any restrictions that the Plan places on the practice of medicine in connection with the performance of services provided to Plan participants.

(ii) The Quality Assurance Committee shall be responsible for reviewing and making recommendations to the Plan with respect to the quality of care provided to Plan participants and with respect to utilization of medical services by such participants.

(iii) The Grievance Committee shall be responsible for advising and making recommendations to the Plan (a) on procedures for effectively and fairly considering any complaint made by or on behalf of any Plan participant about the

quality of care provided by any physician and (b) on the appropriate action to be taken by the Plan with respect to any physician about whom a complaint has been made.

(iv) The Financial and Administrative Matters Committee shall be responsible for advising and making recommendations to the Plan on reimbursement issues (including fee schedules), the structure of any financial incentive program operated by the Plan, and on any other financial or administrative matter of general concern to the physicians affiliated with the Plan—including, but not limited to, payment procedures, the documentation that physicians must provide to the Plan to qualify for payment, mechanisms for referring patients within the Plan, and methods for verifying coverage of patients by the Plan.

(D) Composition of Committees.

Each Committee established in accordance with this Section shall be comprised of no less than three (3) and no more than five (5) physicians affiliated with the Plan. These physicians shall be selected by the Plan making reasonable efforts to assure that such physicians represent a variety of medical specialties and, where appropriate, of different physicians and medical practices affiliated with the Plan. Each Committee shall designate its own Chair.

Sectiom 5. *Collective Development of Positions.*

Physicians affiliated with a Plan may collectively develop position statements on issues relating to their relationships with the Plan and relationships between the Plan and participants. They may present these statements to the Managed Care Plan either through a Committee established by this Chapter or directly. They may utilize consultants, attorneys, medical societies, or other persons or entities for the purposes of developing and presenting position statements.

Sectiom 6. *Restrictions on Physicians Advising Plans.*

Notwithstanding the foregoing, no independently practicing physicians who serve on any Committee or who otherwise provide advice, recommendations, or position statements to a Plan shall:

(A) Discuss with any other physicians affiliated with the Plan their usual charges or any other pricing to patients outside the Plan;

(B) Collectively boycott or threaten to boycott the Plan if the Plan does not accept a recommendation made by those physicians.

Section 7. *Protection Against Retaliation.*

No physician who serves in good faith on a Committee as described in Section 4 of this Chapter or who participates in good faith in the collective development of a position statement as described in Section 5 of this Chapter, may be terminated by the Plan because of such service or participation.

Section 8. *Antitrust Immunity*

No physician who serves in good faith on a Committee as described in Section 4 of this Chapter or who participates in good faith in the collective development of a position statement as described in Section 5 of this Chapter, may be subject to civil or criminal liability under any federal or state antitrust law, except to the extent that the physician engages in any activity prohibited by Section 6 of this Chapter.

Section 9. *Preemption*

All State and local laws, regulations, ordinances, or other rules that are inconsistent with the provisions of this Chapter are hereby preempted.

Section 10. *Regulations*

The Department of Health and Human Services shall have authority to promulgate regulations to implement the provisions of this Chapter in accordance with the provisions of the Negotiated Rulemaking Act, 5 U.S. C. §§581 *et seq.*

ATTACHMENT D

American Medical Association
Physicians dedicated to the health of America

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April 30, 1992

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Howe & Hutton, Ltd.
20 North Wacker Drive
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Counsel for Chicago Medical Society

Donald S. Clark
Secretary
Federal Trade Commission
6th & Pennsylvania Avenue
Washington, D.C. 20530

Dear Mr. Clark:

Pursuant to 16 C.F.R. 1.1, the American Medical Association (AMA) and the Chicago Medical Society (CMS) hereby request an advisory opinion that would permit the AMA, its constituent medical societies, and its component medical societies to engage in professional peer review of physician fees pursuant to procedures developed by the AMA.[1]

Under the AMA's contemplated program, state or county societies would perform most of the professional peer review of fees.[2] State societies would also act as appellate bodies for opinions or decisions of the county medical societies, and under some circumstances would act as the initial forum for

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1 *Pursuant to the AMA's Constitution, constituent medical societies are "medical associations of states, commonwealths, territories or insular possessions which are, or which may hereafter be, federated to form the American Medical Association." Component societies "are those county or district medical societies contained within the territory of and chartered by the respective state associations."*

2 *The AMA believes that many of these medical societies will adopt the proposed fee peer review procedures if they are found to be compatible with the antitrust laws by the Federal Trade Commission. See the letters of support from state and county societies submitted with this request. Indeed, CMS, which is the largest county medical society in the nation, has chosen to join the AMA in this request because it desires to conduct the review of complaints about physician fees in the manner requested for the procompetitive reasons that are discussed infra.*

peer review of fees. The AMA would participate as the appellate body for opinions and decisions of the state societies, and under rare circumstances would initiate its own peer review proceedings.

The Federal Trade Commission (FTC) has issued advisory opinions about the operation of professional peer review of fees.[3] The FTC has recognized that, properly managed, professional fee peer review can yield important procompetitive benefits.[4] In particular, fee peer review can increase the flow of information about physician fees to patients, enabling them to compare fees when selecting a physician.

However, the FTC has also expressed concern that improperly managed fee peer review could result in price-fixing agreements and the[5] advisory opinions and guidelines issued by the FTC have been so restrictive that few medical societies engage in fee review today. We believe they are unnecessarily restrictive and are thereby depriving patients of an important public service.[6] In particular, we object to the FTC guidelines which advise that:

1. Opinions of the peer reviewers must be advisory only and not coercive—that physicians must not be required either to participate in the review process or to comply with the opinion of the reviewers; and

2. That physicians must not be subject to discipline for charging any particular fee or for refusing to adhere to the opinion of reviewers.

A complete summary of the AMA's proposed procedures for professional fee peer review is included in subsequent portions of this letter. In brief, the procedures would generally adhere to the FTC guidelines, but we make the two important changes described above. The process would involve mediation of

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3 *See, e.g., Medical Society of Passaic County (January 3, 1986); American Podiatry Association (March 13, 1984), and Iowa Dental Association, 99 F.T.C. 648 (1982)*

4 *Ibid., and see "Peer Review and the Antitrust Laws," Remarks of Mark J. Horoschak, Assistant Director for Health Care, Bureau of Competition, Federal Trade Commission, before the AMA National Leadership Conference, February 25, 1990 and for the perspective of the Antitrust Division of the U.S. Department of Justice see "Business Self Regulation, An Enforcement Policy of Cautious Tolerance," Remarks of Charles F. Rule, Assistant Attorney General, Antitrust Division, U.S. Department of Justice, Before the Chicago Bar Association, January 27, 1989*

5 *See fn 3, supra*

6 *Horoschak, fn 4, supra*

complaints about fees, but physician participation would be mandatory under the AMA procedures and physicians can be disciplined for fee gouging.[7] While the emphasis of the AMA's proposed program is on mediation, the AMA and the CMS believe that medical societies should be able to discipline members who engage in egregious conduct.

The AMA and CMS believe that these differences would enhance the procompetitive benefits of professional fee peer review by medical societies. Almost all fee peer review carried on by component societies is in response to patient complaints. Mandatory participation would increase the flow of information to patients about fees, and it would increase patient confidence in the market for physician services. The ability to discipline fee gougers would also increase patient confidence in the market.

When a medical society cannot require a member to participate in fee peer review in response to a complaint, the patient is always unhappy, sometimes harmed and the profession is denied the ability to enforce its code of ethics in a critical respect.

The AMA has had intermittent discussions with prior Chairmen of the FTC for the relief sought here for over seven years. We have sensed greater flexibility and a broader perspective from this Commission on certain matters and we submitted a draft of this request for an advisory opinion to the staff of the Bureau of Competition for an informal reaction. Staff has responded by requesting a substantial amount of information in addition to the material set forth in this request. Some of the questions asked by staff are clarifications that have been addressed by modifying this letter. Other information requested can only be obtained by calling upon the experiences of the constituent and component societies. The AMA and the CMS are in the process of gathering that information and will submit it shortly, but we do not believe it is necessary given the nature of the modifications we are seeking. For the reasons stated here and in the cover letter to Chairman Steiger, it is past time to grant the relief we seek.

The Procedures Proposed By The AMA For Professional Peer Review Of Physician Fees

a. Intent of the AMA's Proposed Procedures

This request for an advisory opinion is being submitted as part of a broad, procompetitive effort to enhance professional self regulation by physicians. The goal is to respond to widespread disenchantment with the health care

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7 *Fee gouging has been long been considered unethical by the profession. See Opinion 6.05, "Fees for Medical Services", in the Code of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (1992).*

system by addressing the complaints of patients, payers, and others about individual physicians in light of the ethical code of the profession. It is essential that physicians address this lack of confidence if the market for physician services is to function effectively. The object of enhanced self regulation is to restore confidence by providing a means to resolve patient and payer complaints about individual physicians and by promoting adherence to high standards of conduct by physicians.

This effort to enhance professional self regulation is procompetitive because it should result in greater protection of patient interests and provide a greater flow of information about physicians to patients, payers, and others. Patients will have greater confidence that their interests will be observed and that they will not be exploited when being cared for by a physician. In addition, there will be more information available for patients to compare the characteristics of physicians when choosing a provider. Further, individual physicians will obtain more information about the patient perspective and are likely to respond by changing their practice procedures to improve the experience of the patient.

The AMA hopes to achieve enhanced self regulation by reviving a professional peer review structure that was once active, but which has become increasingly inactive in certain matters in recent years. The AMA and its constituent and component societies have in place the organizational structure necessary to handle complaints about fees and other matters from patients, payers, and others. In fact, most of these medical societies have bylaws that provide for standing committees designed to mediate and resolve patient grievances and to discipline members that engage in unethical conduct. Some of these societies hear patient complaints about fees. However, these committees have become inactive or underused in many, if not most, geographic areas. There are some county and state societies with active grievance committees, but most do not review complaints about fees. The disciplinary function has virtually stopped in most areas.

The AMA has proposed the fee peer review procedures at issue in this request for two reasons. First, The AMA and the constituent and component medical societies view fee peer review as an important activity. Second, because of its importance, an FTC approved set of procedures that enhances the ability of these committees to mediate complaints about fees and to discipline fee gougers would provide an excellent means to promote the use of the peer review system. As is discussed in the next section of this letter, one of the reasons why the peer review structure has become increasingly inactive is fear of litigation, especially antitrust litigation. An advisory opinion from the FTC which found that the proposed guidelines for fee peer review are compatible with the antitrust laws would provide assurances to medical societies that peer review can take place without excessive liability risks.

Medical societies consider professional fee peer review to be important because most medical societies regularly receive complaints from patients a

other persons alleging that a physician charged an unreasonably high fee. The complaints are made with the expectation that the medical society will be able to provide relief. In addition, on some occasions legislators and others have criticized medical societies for not doing more about physicians who overcharge. On a broader level, much concern has been expressed about rising health care costs and society's ability to pay for them. Medical societies want the ability to respond to these complaints and issues.

Another reason why fee peer review is considered to be important is that other issues often underlie and give rise to complaints about fees. Often these problems do not involve egregious or unethical conduct, but they are important for physicians to learn about and address. They include poor communications about the nature of the services provided by the physician, insensitive treatment by the physician or the physician's office staff, and patient dissatisfaction with the outcome of services. Physician fees often become the lightning rod for dissatisfaction with physician services. Mediation of fee disputes is an excellent way for these complaints to surface and be resolved. Medical societies believe that it is important for physicians to respond to these complaints in order to restore patient confidence in the market for physician services. It may be even more important to resolve these issues than to mediate fee disputes.

Another type of issue that often underlies complaints about fees is lack of agreement between physicians and patients about how services will be billed. For example, one type of complaint is colloquially known as "unbundling." That involves charging separate fees for services that a patient or payer believes should be combined into one service with one fee. Usually it is alleged that the fees charged for the unbundled services add up to a charge that is greater than the appropriate fee for the bundled services. The issue of service definition has become important in disputes about physician fees. Again, mediation is an ideal way to address this issue.

There are situations where egregious misconduct underlies a complaint about fees. For example, fee gouging is often accompanied by other unethical activity, such as fraud, taking advantage of a poorly informed patient, undue influence over a vulnerable patient, or the intentional provision of unnecessary services. There is a broad perception that physicians who engage in egregious misconduct are not punished, and are instead allowed to repeat their misdeeds. Medical societies believe that it is important that physicians who engage in egregious misconduct be held accountable if patient confidence in the medical profession is to be restored.

Finally, the AMA believes that enhancing professional fee peer review and physician self regulation in general will serve an important societal need. Patients want to have their complaints addressed, and the medical profession believes that it has the tradition and structure necessary to do the job effectively. Historically, the profession itself, as opposed to other

institutions or regulators, has done the best job at taking the actions necessary to build public confidence in the market for physician services.[8]

b. The Existing Committee Structure

1. Patient Grievance Committees and Physician Disciplinary Committees

As of 1987, almost all of the county medical societies had "patient grievance committees" (PGCs) and physician disciplinary committees (PDCs).[9] The purpose of a PGC is to take complaints from patients about physicians and to resolve them, primarily through mediation. If a complaint involves a serious charge of misconduct, the PGC may refer it to a PDC or to a state or federal regulatory agency. PDCs hear serious charges of ethical violations by a physician that might result in an action that affects the physician's membership.

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8 *Throughout its history, the profession has responded to the need to solve health care problems and to regulate itself in the public interest. During the mid and late 19th century, the profession organized medical societies and developed a code of ethics to distinguish physicians from the many competing health care practitioners that did not adhere to safe and scientific methods. Subsequently the profession initiated and helped operate the system of state licensure of allopathic physicians. At the turn of the century, the profession reformed the medical education industry and succeeded in eliminating the practice of granting diplomas for a fee and in closing substandard medical schools. A system of accrediting medical schools was developed that continues today, and which is operated by organized medicine. During the early part of the twentieth century, systems for accrediting graduate medical education programs and hospitals were developed by the profession, and the board certification of the American Board of Medical Specialties was organized. The net result has been the training of hundreds of thousands of physicians of high levels of competency and integrity, and their efforts to deliver high quality medicine has been an extraordinary success story. The impetus and basic organizational structure for the system has come from the profession itself, in particular, the American Medical Association. See generally, Morris Fishbein, M.D., A History of the American Medical Association, 1847-1947, W.D. Saunders Company, Philadelphia, Pa. (1947); Frank D. Campion. The AMA and U.S. Health Policy Since 1940, American Medical Association, Chicago, Illinois (1984); and Paul Starr, The Social Transformation of American Medicine, Basic Books, New York (1982).*

9 *Directory of Activities, Volume II, 1987, State and County Medical Associations American Medical Association, Chicago, Illinois (1987)*

State medical societies also operate PGCs and PDCs. However, county medical societies are intended to handle initial complaints, with state medical societies acting as an appellate body for parties dissatisfied with the opinions or decisions of the county societies. State PGCs and PDCs will handle initial complaints for counties in rural areas that do not have sufficient members or staff to operate committees. In addition, state PGCs and PDCs usually have discretion to handle initial complaints from any area in appropriate situations.

The AMA does not have a PGC or a PDC. However, the Council on Ethical and Judicial Affairs of the AMA (CEJA) acts as an appellate body for parties dissatisfied with opinions or decisions of state PGCs and PDCs. CEJA also is authorized to conduct its own investigation and hearings into charges of unethical conduct in appropriate situations.

The most active PGCs are operated by county societies that cover large metropolitan areas. These counties have a substantial membership, sometimes larger than rural states, and have the resources to operate active PGCs. The AMA believes that many counties do not have active PGCs, and states are not very active in this area either.

Counties and states have not been active in operating PDCs. The AMA does not have precise information about the operations of PDCs, but it appears that PDC activity has almost halted except in a few large states or counties.

There are several likely reasons for the low level of activity in PDCs. One is fear of litigation. As of 1987, ten state societies and 13 county societies reported that they had been investigated by the FTC, the United States Department of Justice (DOJ), or another government agency during the previous five years. Ten state societies and 20 county societies were sued by a member or a nonmember physician during the same period.[10] Many of the investigations and lawsuits concerned antitrust issues associated with membership. Defense of a lawsuit is a major expense to a state or county society. Many have decided to minimize their exposure to lawsuits by reducing PGC activity and PDC activity.

In addition to fear of litigation, other factors that may cause a low level of activity are a shortage of resources, and a natural disinclination to engage in disciplinary functions that might adversely affect a peer. These factors, combined with fear of becoming embroiled in expensive litigation, have been powerful disincentives.

Currently, the AMA is encouraging county and state medical societies to activate their PGCs and PDCs. As part of this effort, the AMA is preparing to

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10 *Directory of Activities*, Fn 10, *supra*

handle more appeals from state PDCs and PGCs, and it is also providing guidance to state and county societies about how to operate the committees.

2. Chicago Medical Society's Existing Committees

Pursuant to its bylaws, the CMS has standing Ethical Relations and Physicians Review Committees and Subcommittees on Fee Mediation and on Medical Practice. Under the CMS bylaws, failure to cooperate with these committees and subcommittees is grounds for discipline. However, as a matter of custom and practice, CMS has excepted fee peer review from mandatory participation. Members have not been required to cooperate with fee peer review and have not been disciplined if they refuse to participate.

The CMS Ethical Relations Committee is comparable to a PDC and is responsible for disciplinary actions against members, which could include censure, probation, suspension or expulsion.

The CMS Physicians Review Committee is comparable to a PGC. Its Subcommittee on Medical Practice is responsible for complaints concerning the quality and utilization of medical care and has as its goal to open up communications, through mediation, to reach a mutually satisfactory resolution. The Subcommittee's opinion is advisory and nonbinding. An opinion adverse to the physician may be appealed to the Physicians Review Committee and, in turn, to the Illinois State Medical Society.

The Subcommittee on Fee Mediation is responsible for complaints concerning physician fees and has as its goal to open up communications, through mediation, to encourage a mutually satisfactory resolution. The Subcommittee's opinion is advisory and nonbinding. If it is the opinion of the Subcommittee that the fee is above the range of usual and customary fees charged in the geographical area for similar medical services, the physician may appeal to the Physicians Review Committee. Decisions rendered by the Physicians Review Committee in a fee mediation case cannot be appealed.

The efforts of CMS' Subcommittee on Fee Mediation have been frustrated by the Subcommittee's inability to discipline physicians engaged in egregious conduct, such as repeated instances of fee gouging.

c. Guidelines for the Operation of PGC's & PDCs

As stated earlier, the AMA has developed guidelines for the operation of PDCs and PGCs. These guidelines include procedures for ensuring basic fairness to the parties involved, such as minimizing conflicts of interest among reviewing physicians and other "due process" style safeguards. In addition, the guidelines have other features designed to provide for the appropriate disposition of various types of complaints. Many of the guidelines are drawn from the historical practices of the PGCs and PDCs, and some of the guide-

are new. As a whole, the guidelines are a blend of existing practices and new recommendations.

These guidelines apply to all types of complaints handled by PDCs and PGCs, including the handling of complaints about fees. The guidelines also include a section about the handling of fee complaints in particular. The general guidelines are summarized below, and a summary of the guidelines for fee complaints follows immediately after.

1. General Guidelines

The AMA recommends that PGCs and PDCs screen complaints immediately after receipt to determine whether they should be handled by the committee, or referred to another committee or entity, or both. For example, state PGCs should generally refer complaints to the county PGC where the physician involved resides. PDCs should refer complaints that do not involve serious charges of misconduct to PGCs, and PGCs should refer complaints to a PDC when there is reason to believe that serious misconduct is involved.

If there is reason to believe that a threat to the health of the physician's patients exists, then the state's licensing board and the physician's hospital should be notified immediately. When there is reason to believe that a violation of law has occurred, then the appropriate government law enforcement agencies should be notified. A PGC or PDC might hold parallel proceedings when a state licensing board or licensing agency is notified, or it might wait for the outcome of any government actions, depending on the circumstances.

After screening of a complaint by a PGC, it should be investigated by one or more members of the PGC. An investigation should include interviews of the complaining party and the physician complained of[11], interviews of other physicians in the physician's field of practice, review of relevant documents, and other materials. Upon completion of the review, the reviewer should make a report to the full PGC, which should then make one of the following findings: (a) the physician did not act improperly, (b) the matter should be referred to the PDC and/or another entity for further proceedings, (c) the physician acted inappropriately but not enough to warrant disciplinary proceedings or proceedings by an outside agency, or (d) efforts should be made to resolve the matter through mediation. In situations where a physician has acted inappropriately, but not enough to warrant further proceedings, the PGC may require the physician to receive some education and agree to desist from the inappropriate conduct.

During mediation, the PGC should encourage the physician and the complainant to fully discuss their relative positions, with a view towards arriving at a

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11 *At the present time, physician cooperation with investigations of fee complaints is voluntary.*

settlement. Mediation should include education of both the complainant and the physician regarding the appropriate expectations and conduct of each. While settlements are voluntary, the medical society may also require the physician to pursue certain educational activities as a condition of the settlement. The educational activities are designed to prevent repetition of the conduct which led to the complaint.

PGC decisions may be appealed. Some societies allow internal appeals from the PGC decision, others do not. Once proceedings are final at the society which heard the complaint, the decision may be appealed to the next level of society. Counties appeal to states, and the state PGC decisions or appellate decisions can be appealed to the AMA. During appeals, complaints are not reinvestigated. The PGCs findings of fact are accepted if reasonable in view of the record.

PDCs should be independent of PGCs -- there should not be overlapping membership between the two committees in a society. The procedures followed by PDCs are also more formal. They are designed to qualify for the safe harbors provided by the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11111 et seq., which immunizes the participants in good faith peer review from civil liability if procedures designed to ensure fairness to the physician under review are followed. The procedures are also tailored in any given state to meet additional requirements imposed by state law for the conduct of peer review. Specific steps are spelled out for providing notice of the grounds for potential disciplinary action, notice of the disciplinary proceedings, the conduct of the hearings, providing notice of the decisions, and appeals.

A physician found by a PDC to have engaged in unethical conduct may be subject to a range of sanctions[12]. They include:

(a) Requiring the physician to undertake a specific program of remedial education.

(b) Requiring the physician to participate in a program of public service.

(c) Reprimand, censure, suspension of membership or expulsion from membership.

(d) Monitoring of the physician's practice for a specified period of time to ensure that corrective action has been taken.

(e) A fine to be paid to the medical society, or, if appropriate, restitution to the patient.

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[12] At the present time, sanctions do not apply to fee gouging.

(f) Report to the state medical board with a recommendation that action or investigation be initiated.

(g) A combination of the sanctions listed in (a)-(e).

Factors in determining a sanction include not only the severity of the misconduct, but whether it was a first offense or part of a pattern of misconduct. More serious sanctions can also follow if, for example, a physician fails to participate in a program of remedial education or public service.

As is the case with PDCs, appeals may or may not be available within the society. Once the decision is final, it may be appealed to the next level, normally a state society, and then to the AMA.

Adverse actions taken by a PDC may be subject to federal and state reporting requirements. Under the federal Health Care Quality Improvement Act, any "professional review action" which adversely affects the membership of a physician must be reported to the state licensing board, which in turn reports to the National Practitioner Data Bank. Under the Act, "professional review actions" are those based on the competence or professional conduct of a physician, where the professional conduct affects or would adversely affect the health or welfare of a patient[13]. An action adversely affects membership by reducing, restricting, suspending, revoking, denying, or failing to renew membership.[14]

Many states require by law that determinations of unprofessional conduct related directly to patient care be reported to the licensing board. In addition, a PDC may make other disclosures. If there is a finding that substandard care has been provided, the peer review committee of the physician's hospital should be notified. Normally, reports of adverse actions by PDCs should be disclosed to the society's membership and the public through vehicles such as state medical society journals. However, in some cases it may make sense to impose a sanction privately, as where the offense is not

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13 *It is uncertain whether fee-gouging would fall within the definition of a professional review action. Economic injuries such as being overcharged do not seem likely to affect the "health" of patients, but they might be considered to affect the "welfare" of patients.*

14 *A physician who is being considered for disciplinary action may seek to avoid the procedure by resigning. Under the Health Care Quality Improvement Act, resignations which take place during the pendency of a hospital peer review procedure must be reported. However, it is not clear whether resignations during the pendency of a medical society peer review process must be reported.*

egregious and the physician is a first time offender, or where there is a referral to an impaired physician program.

Ordinarily, PGCs and PDCs will have jurisdiction over medical society members only. Participation and cooperation with PGC and PDC activities is mandatory, and failure to cooperate is grounds for discipline. However, the AMA recommends that county and state societies encourage nonmembers to participate in PGC or PDC proceedings when complaints are received about them. In practice, some societies will accept a complaint about a nonmember only if the physician agrees to abide by the PGC or PDC procedures and decision. In the absence of an agreement, these societies will refer the complaint to the state licensing board or to another appropriate institution. Other societies will process a complaint against a nonmember without the nonmember's consent. The AMA believes that serious complaints about non-members who refuse to participate in a professional society's fee review process should be referred to the state licensing board.

Complaints may be filed by any person. Most commonly complaints are filed by patients, but they may also be filed by family or friends of patients, colleagues of the physician, or by third party payers.

d. How Fee Complaints Would Be Handled By PGCs and PDCs

Complaints about fees would be handled according to a specific set of procedures newly developed by the AMA. All fee complaints would first be referred to a county PGC covering the area where the physician resides, or the applicable state PGC if there is no county PGC. All complaints would be screened by the PGC to determine whether they should be referred to a state licensing board or a government enforcement agency. No complaints would be referred to a PDC without first being investigated by a PGC.

After investigation, a PGC would determine whether a fee complaint was a "level I" complaint or a "level II" complaint. A level I complaint would be a complaint that did not involve egregious conduct by the physician involved, and a level II complaint would be one which involves an allegation of egregious conduct that has a credible foundation. Egregious conduct would include situations where the fee charged arose from fraud, the exercise of undue influence over a vulnerable patient, taking advantage of the lack of knowledge of a patient, failing to inform a patient that an unusually high fee would be charged, intentionally providing unnecessary services, or other misconduct. It would also include charging a fee so high, for example two or three times the market level for a major procedure, as to constitute fee gouging[15]. Fees much higher than normal would not constitute fee gouging if

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[15] *FTC staff has asked for clarification about what constitutes fee gouging and in particular, what standards would be used to evaluate whether fee gouging occurs. The current reference point for what constitutes gouging is provided by Opinion of the Code of Medical Ethics and Current Opinions of the Council on Ethical and*

(Footnote continued on next page)

agreed to by a fully informed and competent patient or payer that was not subjected to undue influence. Complaints about fee gouging made by colleagues of the treating physician or by persons other than the patient would be reviewed to determine if the fees involved had been agreed to by a fully informed and competent patient. If there was such an agreement, the complaint would not be acted upon[16].

(Footnote continued from previous page.)
Judicial Affairs of the American Medical Association (1992), which is entitled "Fees for Medical Services". The Opinion states as follows:

> *A Physician should not charge or collect an illegal or excessive fee. For example, an illegal fee occurs when a physician accepts an assignment as full payment for services rendered to a Medicare patient and then bills the patient for an additional amount. A fee is excessive when after review of the facts a person knowledgeable as to current charges made by physicians would be left with a definite and firm conviction that the fee is in excess of a reasonable fee. Factors to be considered as guides in determining the reasonableness of a fee include the following:*
>
> > *A. the difficulty and/or uniqueness of the services performed and the time, skill and experience required;*
> >
> > *B. the fee customarily charged in the locality for similar physician services;*
> >
> > *C. the amount of the charges involved;*
> >
> > *D. the quality of performance,*
> >
> > *E. the nature and length of the professional relationship with the patient; and*
> >
> > *F. the experience, reputation and ability of the physician in performing the kind of services involved.*

16 *FTC staff has asked what the effect of a prior agreement between the physician and patient would be if the patient subsequently alleged a fee to involve fee gouging. If the patient was fully aware of what other physicians were charging for the services when the agreement was entered, and if the patient was not misled about some other factor which might lead a reasonable person to pay more than the market rate for a service, then the patient would be viewed as not having a valid complaint and the fee would not involve gouging. However, if the patient was not aware of the market rate, or was misled into believing that the presence of another factor warranted paying substantially more than the market rate, then the patient would be viewed as having a valid complaint*

All level I complaints would be referred for mediation by the PGC. Level II complaints are those involving egregious conduct. The underlying patient or payer grievances in level II complaints would go through mediation for the purpose of resolving the complaints. However, level II complaints would also be referred to a PDC to evaluate whether the physician involved should be disciplined.

During mediation of complaints, each party would express views about the fee involved and any other conduct which gave rise to the complaint. The panel would express opinions about the reasonableness of the fee charged and the appropriateness of any other behavior at issue. Panel opinions would be based on their own expertise and experience in view of the circumstances of the complaint. The panel would consider the nature of the services performed, the difficulty of providing the services to the patient involved, any unusual problems or complexities that had to be managed, and other factors.

The opinions of the panel about the fee could be supplemented with other information about fees obtained from payer data bases, government fee schedules, academic studies, and the opinions of similarly situated physicians sought out by the panel. However, the medical society involved would not collect and maintain its own information about fees charged by physicians in its jurisdiction for use as a benchmark. Likewise, opinions of the panel about any other behavior of the physician involved could be supplemented by ethical codes and ethical opinions, articles about physician ethics, academic studies about the effects of certain conduct, and other materials. The object of the process would be to allow each side to gain an appreciation for the perspective of the other, and to be educated about the legitimate expectations of each party in the physician-patient relationship.

The goal of mediation would be to arrive at a settlement between the physician and the complaining party. No person, including the physician, would be required to agree to a settlement. However, participation in mediation by member physicians would be mandatory, and failure to cooperate with mediation would be grounds for discipline. Refusal to enter a settlement by a physician would not constitute lack of cooperation. Participation by the complaining party would be voluntary.

Settlements would not be limited to fee adjustments. The PGC could suggest, and the physician might agree to, other undertakings by the physician. These would be nonprice undertakings designed to educate physicians about how to prevent the type of incidents that give rise to patient complaints. These include how to manage the physician's office in ways that are considerate of the needs and interests of patients, how to communicate with patients, how

manage billing procedures so as to prevent errors, and other issues. For example, if repeated complaints about a physician are found to result from coding errors on claims forms, then education about coding may be appropriate.

If warranted, the PGC could require a physician to engage in a nonprice undertaking designed to prevent future complaints or misconduct. While these undertakings might arise out of mediation of the fee dispute, they would be directed towards nonprice issues that came to light during review of the complaint.

Proceedings during mediation would be kept confidential. No part of the proceedings would be open to the membership or the public. The report of the initial investigation would be kept confidential, and any record created or documents collected would also not be disclosed. Likewise, any settlement reached, including settlements that are conditioned on nonprice undertakings, would not be disclosed to the membership or to the public.

PDCs would review level II complaints to determine whether the physician should be disciplined. The procedures specified by HCQIA would be followed to ensure fairness to the physician charged with unethical conduct. Participation in the PDC proceeding would be mandatory for the physician involved.

PDCs would keep their proceedings confidential. However, PDC decisions would be publicly disclosed. No information about the fee levels involved in a discipline for fee gouging would be disclosed, but the occurrence of the discipline would be made public. The purpose of disclosure would be to inform the public about the discipline.

The FTC Guidelines for Professional Peer Review of Fees

FTC staff have noted that, properly managed, professional peer review of physician fees results in three procompetitive benefits.[17] First, it is a means of providing information to patients about physician fees and other issues. That is procompetitive because the information allows the patient to decide whether a fee is excessive in relation to those charged by other physicians. It is an important benefit because there are often wide disparities in fee information between patients and health care providers.

Second, fee peer review can be an efficient and low cost method for resolving disputes about fees between physicians, patients, and payers. That is procompetitive because it facilitates the expedient and fair resolution of disputed transactions. At present, there is no effective forum available to

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17 *See Horoschak and See Rule at fn. 4, supra*

resolve disputes. Courts are expensive and difficult to use, and they are often very slow. State licensing boards are not designed to resolve individual disputes. Instead, they investigate physicians in response to complaints. At present, most licensing boards have sufficient resources to investigate only the most serious complaints.[18]

Third and finally, fee peer review builds confidence in the market for physician services. Patients develop confidence because they believe that they will be treated fairly, and that they will receive objective information in the event of a dispute.

However, an improperly managed fee peer review program can be anticompetitive and violate the antitrust laws. FTC advisory opinions note that antitrust violations may occur if fee peer review becomes a device to coerce physicians to adhere to certain fee levels or to coerce payers into accepting fee levels, if it is used to discipline physicians who engage in legitimate competitive activities or innovative practices that are frowned upon by other practitioners, or if it becomes a vehicle for physicians to agree among themselves about fee levels.[19]

The advisory opinions note that antitrust violations can be avoided if all concerned parties view fee peer review solely as a means of mediating specific fee disputes, rather than a process for the collective sanctioning of fee levels or particular practices. Mediation involves the expression of opinion by peer review panel members about a fee charged for a particular service provided to a patient. That expression of opinion allows the patient or payer involved to decide whether to pay the fee in question.

Certain guidelines designed to prevent anticompetitive abuse of fee peer review can be drawn from the FTC advisory opinions. These guidelines can be summarized as follows:

(1) Participation in professional peer review of fees is voluntary for the physicians and any complaining or affected party, such as the patient. The FTC is concerned that proffered guidance in fee peer review could become coercive if the process is not voluntary.

(2) Determinations made by the peer reviewers about the physician's fees are advisory, and have no coercive aspects. The FTC is concerned that coercive determinations could threaten independent pricing.

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18 *"State Medical Boards and Medical Discipline," Inspector General, Department of Health and Human Services (August 1990)*

19 *See Advisory Opinions cited at fn 3, supra*

(3) Peer review decisions about fees are based solely on the facts and circumstances of the particular case. The FTC is concerned that independent pricing could be threatened if determinations about particular past prices become generalized in future fee peer review opinions.

(4) Peer review decisions about the appropriateness of fees are kept confidential and are not disclosed except to the physician and complaining patient or payer. The FTC believes that dissemination of peer review opinions about fees could threaten independent pricing.[20]

(5) The association of physicians sponsoring professional peer review of fees does not collect information on fees charged by its members and does not use the information to establish a pricing benchmark. The FTC believes that the difficulty and complexity of a procedures should be evaluated based on the individual judgment and expertise of the peer reviewers. To the extent that any reference is made to external factors or benchmarks, consideration should be limited to fee information not sponsored or sanctioned by the medical society.

For the most part, the procedures proposed by the AMA would adhere to these guidelines, but there would be some significant departures. In particular, the proposed process would not be voluntary in all respects. The emphasis of the program would be mediation, but participation would be mandatory for members. Participation would be required because the public would not be well served by a peer review process that members could ignore when patients file complaints about them.

For the same reasons, the program would be coercive in some situations. Medical societies would discipline members who engaged in egregious fee gouging. The purpose would be to give the public confidence that physicians who engage in egregious fee gouging will be held accountable.

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20 *The AMA understands that confidentiality is limited to information about the fee level itself as opposed to the fact of a peer review action. The AMA believes that medical societies may publicize information about the number and nature of peer review actions taken, and could publicize the names of individuals disciplined for fee gouging, provided that the fee amounts involved were not disclosed.*

The AMA's Proposed Procedures For
Peer Review of Fees are Procompetitive

The judicial decisions relevant to peer review of fees are generally consistent with the current policy of the Commission in that they would permit self-regulation activities that do not constitute or enforce a price-fixing agreement. The AMA's proposed procedures for peer review of fees would clearly fall within the range of conduct deemed reasonable by the courts, and any departures from existing FTC guidelines would be procompetitive and lawful.

The Supreme Court has held that an agreement affecting price should only be condemned after a "quick look" to determine whether it has clear anticompetitive consequences and lacks any redeeming virtue. Broadcast Music, Inc. v. Columbia Broadcasting System, Inc., 441 U.S. 1, 19-20 (1979). As noted above, the Commission recognizes the procompetitive benefits that result from peer review of fees. The AMA's proposed fee peer review is thus not inherently suspect; it presents antitrust concerns only if the fee peer review serves to establish or enforce a price-fixing agreement.

The AMA's proposed process contains several elements designed to assure that the peer review conducted will not establish or enforce a price-fixing agreement. First, the PDCs will act on a complaint of alleged fee gouging only (1) when the complaint originates with a patient, or (2) when the complaint originates with another physician and the patient states that he or she either did not agree to pay the high fee, or would not have agreed to pay a fee that was extraordinarily high in comparison to those charged by comparable physicians. Only in extreme circumstances, such as where there is evidence of fraud or a mentally impaired patient, would a PDC pursue fee peer review when the patient is satisfied with the fee charged. This policy limits the possibility that a fee peer review action will be undertaken for the purpose of enforcing a price-fixing agreement among physicians. It would also focus fee peer review activity on those cases in which an imperfect information exchange between physicians and patients has created a distortion in the market which the physician has used to his or her financial advantage.

Second, PDCs will not develop any formal or informal benchmark schedule of reasonable fees with which to resolve fee disputes. Each allegation of fee gouging will be addressed under the unique circumstances in which it arose, and the PDC will simply determine whether the fee charged in that case was excessive. Third, there will be no public disclosure of any fee amounts determined to be excessive, or of the PDC's view of the reasonable fee in each case. These latter two elements limit the possibility that fee peer review will facilitate the development of a price-fixing agreement by physicians.

The Commission has expressed its concern that fee peer review may be used improperly to discipline physicians who compete by offering a new product or service. The substantial due process procedures contained in the AMA's proposal are intended to lessen the possibility of exclusionary conduct [illegible]

guise of peer review. The courts recognize that industry self-regulation is usually found lawful when such procedural safeguards are employed. Allied Tube & Conduit Corp. v. Indian Head Inc., 486 U.S. 492 (1988); Silver v. New York Stock Exchange, 373 U.S. 341, 364-67 (1963).

Finally, the Supreme Court's decision in Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982), is not inconsistent with the AMA's proposed process. In Maricopa, the physicians clearly agreed to limit their charges to patients who contracted with a particular insurer. The AMA's proposal involves no such agreement affecting price, and fee peer review is not likely to result in price-fixing. The courts have noted that if an ethical rule is not itself illegal, neither is enforcement of the rule. See, e.g., Vogel v. American Society of Appraisers, 744 F.2d 598 (7th Cir. 1984).

The AMA's proposed procedures for peer review of fees generally adhere to the guidelines developed by the FTC for a procompetitive fee peer review program. The limited ways in which the proposed procedures depart from the FTC guidelines are designed to make enforcement of the ethical rule against fee gouging more effective in a procompetitive manner. These departures actually reinforce the core concepts underlying the FTC guidelines and will not have any anticompetitive effects.

The departures from FTC guidelines in the AMA proposed procedures are as follows:

- Participation in fee peer review by members is mandatory.
- Members who engage in egregious conduct, including fee gouging, may be disciplined.
- Discipline for egregious conduct will not be kept confidential.

Each one of these departures will be discussed below.

a. Mandatory Participation Of Members In Fee Peer Review and Mediation

A primary procompetitive benefit of fee peer review is to provide information to the patient about physician fees and charges. The process helps reduce the disparity of information between physicians and patients. The information helps the patient decide whether to pay all or a portion of the fee in question, and whether to patronize other physicians.[21]

Mandatory participation in fee peer review by medical society members improves the information made available to the patient during mediation. A physician

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21 Horoschak, supra, footnote 4

who cooperates with the PGC will provide patient records and other documents, will discuss the physician's perspective about the patient's treatment, and will explain the reasons for the fee. There will be a much better basis upon which to judge whether the fee was reasonable, whether the physician made any mistakes in billing, whether there was a foundation for nonprice complaints by the patient, and other matters.

In addition, the physician receives information from the patient that may help the physician operate a more competitive practice. The physician may find out about office management problems that need to be corrected, about office staff that are not interacting well with patients, or about problems that the physician has in communicating with patients. In addition, the PGC can help inform the physician about educational programs that can help correct the problems revealed during mediation.

Finally, mandatory participation increases the likelihood that settlements acceptable to the patient and the physician can be arrived at. Satisfactory settlements build confidence in the market for physician services. Patients develop confidence that they will be treated fairly, and that they can have complaints resolved.

Mandatory participation in PGC proceedings is not anticompetitive because the focus is on mediation. The only requirement is that the physician participate, not that the physician adhere to any fee or fees recommended by a PGC or the medical society. Further, the physician is not subject to discipline by the PGC for fees charged. (Mandatory participation in disciplinary proceedings conducted by the PDC is discussed below). Participation in remedial education may be required, but only for nonfee aspects of the physician's practice.

b. Disciplines for Fee Gouging

The possibility of PDC discipline for egregious conduct is procompetitive. It provides the patient with information about physicians who have engaged in unconscionable fee gouging or other misconduct. That allows the patient involved and other patients to decide whether or not to continue dealing with the physician. In addition, it builds confidence in the market because patients know that physicians who engage in egregious conduct can be held accountable.

Discipline for fee gouging is not anticompetitive. In most situations, the complaint about an egregious fee will arise out of nonprice conduct such as fraud, the provision of inappropriate services, the provision of substandard services, or other misconduct. Disciplinary actions that are primarily based on such misconduct do not reflect a maximum price fixing agreement. Even if the discipline concerns fee gouging only, it will not likely reflect maximum price-fixing. Patients who complain about being gouged normally have not agreed, with full information about comparable fees and the quality and need of the service being offered, to pay a fee that is extraordinarily high. Such a patient normally will not have been informed about the extraordinary nature of the fee before receiving the service and, if so informed, would not have agreed to it in advance. Therefore, these are transactions that would not have occurred but for disparities in information between the physician and the patient.

It is unlikely that a patient who, for whatever reason, agreed to an extraordinarily high fee while being fully aware of the fees charged by comparable physicians will file a complaint. Such incidents are likely to be few, and the PDC will address them only in extreme circumstances.

The colleagues of a physician who charges extraordinarily high fees may complain to the applicable medical society. Disciplinary actions that result from a physician complaint about another physician's high fees might reflect enforcement of a maximum price-fixing agreement. However, as discussed above, that possibility can be remedied by restricting discipline to situations where there are patient complaints. If a physician complains about a colleague who charges extraordinarily high fees, a PGC would investigate to determine

whether the physician's patients were fully informed and agreed to pay the fee without being subject to undue influence. If the patients were generally satisfied, there would be no grounds for discipline.

c. Disclosure of Discipline

Finally, publicly disclosing disciplinary actions for fee gouging is procompetitive. It provides information to consumers about physicians who have been charging extraordinarily high fees in situations that have been unfair to patients. That helps patients decide which physicians to patronize, and it builds confidence in the market for physician services.

Moreover, public disclosure of disciplinary actions provides a deterrent effect among the physician community and increases the effectiveness of enforcement of the profession's ethical code.

No information would be disclosed about the fees charged by the physician disciplined or the fees considered reasonable by the PRC. Therefore, disclosure would not constitute a signal about the fee levels that could facilitate a physician fee agreement on fees.

d. Effect on Health Care Expenditures

FTC staff has asked whether the proposed procedures for professional fee peer review will reduce health care expenditures. The AMA cannot promise that precisely discernible savings will result that will be directly attributable to the procedures, but the AMA and the CMS expect that the procedures will help control health care costs. As stated earlier, the program is designed and intended to comply with the antitrust laws and therefore will emphasize the mediation of fee disputes. The program will not, and cannot under the law, be a fee control program which could result in precisely discernible and quantifiable savings. It is expected that the program will reduce the incidence of fee gouging, and therefore result in some directly attributable savings, but fee gouging is not common and its elimination is not expected to result in substantial savings overall. It is expected that the program will help detect and reduce the incidence of fraud, which should also result in cost reductions.

In addition, the information provided to patients through the peer review process will enable them to compare physician fees more effectively, and it will give them a better understanding of medical practice and medical decision making that should make them more effective consumers. The process should also help patients develop a better understanding of what benefits are realistic to expect from physicians, and the extent of the resources that are necessary to provide effective health care. Also, physicians will become more sensitive to the complaints of patients and will change their practice patterns to respond to them. The result of more informed consumers and more sensitive physicians should be an improved market.

Conclusion

For the reasons stated above, the AMA and CMS believe that the AMA's proposed fee peer review procedures will be procompetitive and facilitate the operation of the market for physician services. Equally important, the procedures will enhance the protection of patients where the market does not operate efficiently and thereby increase the trust of patients in their physicians, which is the heart of the physician/patient relationship. The AMA and CMS request an opinion that the proposed procedures are not anticompetitive and would not be subject to FTC enforcement actions.

Sincerely,

Kirk B. Johnson, General Counsel
Edward Hirshfeld
American Medical Association

John M. Peterson (02)
John M. Peterson
Howe & Hutton, Ltd.
Counsel for Chicago Medical Society

Responses of Dr. Schenken to Questions Submitted by Senator Rockefeller

Question One -- *In your testimony you say that antitrust statutes and enforcement have severely restricted your ability to self-regulate and discipline members of the medical community. You note that state and county medical societies' standing committees charged with mediating patient grievances, dealing with complaints about physician fees and disciplining unethical conduct of members are largely inactive or underused. Could you please elaborate on why antitrust has had this effect on your efforts to self-police?*

AMA Response (General) -- State and county medical societies face a number of obstacles in conducting disciplinary activities. Lack of funding is a serious problem and the demands of legally required procedures are increasingly complex. Fear of litigation, including antitrust litigation, is one of the primary causes cited by medical societies when asked what problems prevent them from being more active in peer review activities. Medical societies have been sued over adverse peer review decisions based on legal theories other than antitrust, and the AMA is seeking protection for medical societies from other types of claims, as well as antitrust claims.

An antitrust lawsuit is by far the most feared type of legal claim. Antitrust claims are the most expensive types of claims to defend against, with even a simple antitrust case tried to verdict likely to cost several hundred thousand dollars to defend. Costs in excess of one million dollars are not uncommon. The high cost of potential litigation seriously inhibits the activities of county and state societies. These are not wealthy organizations. The annual cost of handling a single antitrust lawsuit would exceed the total annual budget of some of these societies and constitutes serious financial hardship for most of the others. Further, insurance that will pay for defense costs and judgments is prohibitively expensive or simply not available. As a result, the leadership of county societies and smaller state societies tend to avoid activities, including peer review, that can lead to litigation, especially antitrust litigation. These activities are avoided even if the leadership is confident that the activities would be carried out in good faith, and that they would be legal. It is the cost of litigation, not the threat of adverse awards, that acts as the primary deterrent. However, in the case of antitrust, the threat of treble damages and awarding of attorneys' fees in the event of an adverse result certainly are a further deterrent.

These fears are not irrational. The experience of a large county medical society which does discipline members, the Dallas County Medical Society, is a good example. During the past four years, Dallas County has expelled three members and denied the applications of three potential members. Two of these actions have resulted in lawsuits that are currently pending. (These two cases do not include antitrust claims at the present time.)

The creation of the National Health Care Practitioner Data Bank by the Health Care Quality Improvement Act of 1986, 42 USC § 11101, et seq., also has increased the risk of litigation. Any action by a medical society that adversely affects membership and which is based on patient care issues must be reported to the data bank. The reporting requirement has increased the tendency of physicians under peer review to threaten litigation if an adverse decision appears likely and to institute a lawsuit if an adverse decision in fact results.

Fee Peer Review -- In 1982, two landmark antitrust cases affecting medical associations were decided by the Supreme Court; American Medical Association v. Federal Trade Commission, 455 U.S. 676 (1982), and State of Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982). In the AMA case, the Supreme Court,in an equally divided decision, affirmed a Federal Trade Commission (FTC) order against the AMA that, among other things, barred the AMA from "restricting, regulating, impeding, advising on the ethical propriety of, or interfering with the consideration offered or provided to any physician in any contract with any entity that offers physicians' services to the public, in return for the sale, purchase or distribution of his or her professional services, except for professional peer review of fee practices of physicians." The Maricopa decision barred medical associations from engaging in any kind of price-fixing, even maximum price-fixing.

While the FTC order could be read as allowing medical societies to engage in professional fee peer review, this was not the case when read together with the AMA and Maricopa cases. Reading these cases together, it appeared that medical societies could not engage in any kind of fee peer review that resulted in an opinion that a physician's fee was too high. As a result, the AMA advised state, county and other medical societies that fee peer review was of questionable legality and ought to be curtailed. Most state and county medical societies took that advice, although some disagreed and continued to engage in the activity.

Also in 1982, the FTC issued guidelines for professional fee peer review in an advisory opinion, Iowa Dental Association, 99 FTC 648 (1982).These were repeated in subsequent advisory opinions of the FTC, Medical Society of Passaic County, (January 3, 1986), and American Podiatry Association, (March 13, 1984), and as recently as three years ago in a speech by an FTC official, "Peer Review and the Antitrust Laws", Remarks of Mark J. Horoschak, Assistant Director for Health Care, Bureau of Competition, Federal Trade Commission, before the AMA National Leadership Conference, February 25, 1990. These statements provided a basis for the AMA to advise county and state medical societies that they could engage in fee peer review, at least within the limits set forth by the FTC.

However, with respect to addressing complaints about physician fees, most medical societies are still concerned about the potential for federal prosecution. Medical society executives have become aware of the aggressive efforts by the FTC and the Antitrust Division of the Department of Justice (DOJ) to prosecute price-fixing in the health care industry and are fully aware of the potential for criminal penalties as well. Most county and state societies see the review of fee complaints as a controversial activity and, therefore, too risky to pursue in spite of the FTC guidelines and our advice on this activity. There are some large and well-staffed county medical societies that do engage in the review of fee complaints, but these are the exception. These societies are large enough to afford antitrust counsel, they have experience in fee complaint review, and believe that they understand the limits of that activity. Societies lacking such resources do not understand or feel comfortable with the risks involved. Clarification in this area still is needed.

Questions Two -- *To follow up, I understand that you have filed a petition with the FTC to remove the prohibitions of the profession to self-police. Precisely what type of immunity from the antitrust laws do you believe you need to improve your own efforts to discipline physicians?*

AMA Response -- The Fee Peer Review Advisory Opinion Request -- On April 30, 1992, the AMA filed a request for an advisory opinion with the FTC requesting that the FTC alter its standards for fee peer review. A large county medical society which engages in fee peer review, the Chicago Medical Society, joined the AMA's request.

The current FTC standards for fee peer review (found in advisory opinions and the above cited speech) allow fee peer review to take place if the following conditions are met:

a. Participation in the fee peer review process by the physician who is the subject of the complaint must be voluntary. A medical society cannot compel a member who has been complained of to take part in a fee peer review proceeding.

b. Determinations made by the peer review committee about a physician's fees must be advisory and must have no coercive aspects. The medical society cannot discipline a physician for charging a fee that is judged to be too high and cannot require that the physician lower the fee as a condition of continued membership.

c. Peer review decisions must be based solely on the facts and circumstances of the case. Determinations about post-pricing decisions by the physician may not become generalized in future fee peer review decisions. The peer review panel may not look at past fee opinions to judge the validity of a fee being reviewed.

d. Any opinions arrived at by the medical society may be shared with the complaining party and the physician complained of, but may not be disseminated to the membership of the society involved.

e. The medical society may not develop predetermined fee schedules to use as a benchmark for evaluation of complaints about a physician's fee.

The AMA's request for an advisory opinion asks the FTC to allow medical societies to compel members to participate in fee peer review proceedings and to discipline members who engage in fee gouging. The AMA has not requested that medical societies be allowed to develop fee schedules or to disseminate the particulars of fee peer review proceedings to members

The AMA's requested modifications represent minimal requirements for allowing medical societies to engage in more effective fee peer review. The modifications requested would not allow medical societies to discipline members that charged a fee that was merely higher than average. Before the discipline would be allowed, the fee would have to amount to fee gouging -- a fee that was so large as to be unconscionable. Further, if a fully informed and consenting patient agreed to a fee that appeared to be unconscionable, that would not amount to fee gouging and could not result in a disciplinary measure. Therefore, even if the request for an advisory opinion was granted by the FTC, it would still be illegal for the AMA or any other medical society to enforce a voluntary maximum fee freeze as has been suggested by some federal policy makers.

The FTC still has not acted upon the request of the AMA and the Chicago Medical Society which was submitted more than one year ago.

The Immunities Requested by the AMA -- Even a positive response to the AMA request made to the FTC is not sufficient to encourage broad scale disciplinary activities by medical societies. For that to occur, immunity from private lawsuits will be necessary. The AMA believes that private parties should not be allowed to sue medical societies or other physician organizations for good faith actions taken as part of quality assurance activities. The interests of individuals adversely affected by quality assurance actions can be protected by preserving the ability of government enforcement agencies to bring civil injunctive actions. The AMA believes that criminal prosecutions for actions arising from quality assurance activities should also be eliminated.

The immunity described above is necessary to reduce the potential litigation costs of quality assurance activities for medical societies to an acceptable level. However, if the type of immunity requested by the AMA is not possible, then, at a minimum, the following changes should be implemented:

i. Elimination of damage awards against medical societies that engage in disciplinary activities; and
ii. Recovery of attorneys' fees from the plaintiff when the medical society successfully defends a case.

Question Three -- *Isn't it true that with state supervision through the state licensing boards or otherwise you would get antitrust immunity under the state action doctrine? The policy has been that if an industry is subject to antitrust or needs immunity, it must be subject to public supervision. Why are physicians different? If we were to give physicians exemptions why not for lawyers, or civil engineers, for architects, or for steel companies?*

AMA Response -- This question suggests that antitrust immunity for peer review activities of medical societies could be achieved by having state licensing boards delegate authority to county and state medical societies. This is a possibility, and the AMA is in fact pursuing this concept through a project with the Federation of State Medical Boards. One medical society, the Medical and Chirurgical Faculty of the State of Maryland, is currently investigating complaints delegated to it by the Maryland medical board. Other medical societies have expressed interest in similar activities with their state boards. However, there are potential problems with this approach.

One problem involves the lack of certainty about the boundaries of the state action exemption to the antitrust laws. The nature of that exemption has shifted considerably over the past twenty years. The Supreme Court sharply curtailed the boundaries of the exemption in the late 1970s and early 1980s, see e.g. City of Lafayette, Louisiana v. Louisiana Power & Light Co., 435 U.S. 389 (1978). The Supreme Court then expanded the boundaries, see e.g. Town of Hallie v. City of Eau Claire, 471 U.S. 34 (1985). Recently, the Court appeared to restrict the boundaries of the exemption once again, see Federal Trade Commission v. Ticor Title Insurance Co., 112 S. Ct. 2169 (1992). Even with this level of Supreme Court activity, uncertainty remains as to when the conduct of a private party acting under the authority of a state entity is in fact within the scope of the state exemption.

Under current judicial opinions about the state action exemption, the AMA believes that a state licensing board that authorizes a state or local medical society to act on its behalf should have state legislative authority to do so. In addition, the state licensing board should make the ultimate decision about the controversies involved and should review the decisions of the medical society. The medical society may safely act as an investigator and initial decisionmaker, but the state would have to be sufficiently involved in the final decision to achieve the exemption. Whether this will remain the law under judicial opinions is uncertain. The AMA believes that federal legislation would be necessary to provide some assurance and stability.

Medical societies acting on behalf of medical licensing boards would also have to be reviewing activities that might adversely affect the physician's license. This results in a more highly charged and resource-intensive process than reviewing activities that might affect a physician's membership. Medical societies should have more flexibility and more ability to become deeply involved in quality assurance activities if they are not acting under auspices of the state's licensing authority.

A further problem remains in that the state actions exemption protects only against antitrust liability. It does not protect against liability for other types of claims.

With respect to whether medical societies should receive an immunity that removes them from public supervision, the AMA agrees that medical societies should continue to be publicly accountable. The AMA does not propose that medical societies be completely immunized from antitrust enforcement with respect to quality assurance activities. Our proposal is that private lawsuits be eliminated, but that government law enforcement agencies be able to bring injunctive actions to bar anticompetitive activities.

Question Four -- *Why do you believe you need immunity from antitrust laws in order to develop and implement practice guidelines? Isn't this an ongoing activity at the federal, state and local level? How about technology assessment?*

AMA Response -- The AMA believes that medical societies that engage in the development of practice guidelines, technology assessment, and outcomes measurement and reporting activities should be protected from private antitrust lawsuits. The reason, again, is to avoid the potentially high litigation costs that inhibit such constructive activities. The AMA practice parameters and technology assessment activities have not yet resulted in any lawsuits (although several lawsuits about technology assessment opinions have been threatened), but this effort is still new. As practice guidelines and technology assessment become more important in the practice of medicine and affect the types of services and products that may be provided, we expect that litigation in this area will increase.

The fear of antitrust litigation in this area is not irrational. Not long ago, the American Academy of Ophthalmology was sued because it issued a 1980 opinion that a procedure to correct myopia called radial keratotomy, was "experimental" and not yet proven safe and effective. The Academy won the case in a decision which resulted in the development of law favorable to the creation of guidelines, Schachar v. American Academy of Ophthalmology, 870 F. .2nd 397 (7th Cir. 1989). In essence, the opinion states that the opinions of medical societies about medical matters are immune from antitrust liability, and that antitrust scrutiny only occurs if a medical society attempts to enforce its opinions.

While the Schachar case is favorable to guideline development and technology assessment, it is only the law in one federal circuit court of appeals. Other federal appeals courts have not yet passed on the issue. Further, if medical societies went beyond developing and issuing guidelines or technology assessment opinions, and began enforcing them through peer review, they are subject to antitrust scrutiny even under Schachar.

The AMA is aware of two situations where actual or potential litigation expenses curtailed technology assessment efforts. The California Medical Association (CMA) had a technology assessment program that resulted in a number of antitrust cases against it by providers of services or products which did not receive favorable opinions. None of these cases resulted in adverse judgment against CMA or in a settlement unfavorable to CMA. However, the costs of defending lawsuits became so great that the program was terminated. One suit alone cost $250,000 to defend, Winter v. California Medical Association, USDC,CD Cal. No. CV-82-35421 WJR. The costs of defending lawsuits became so great that the program was terminated -- although the program is no longer functioning one of the lawsuits is still pending, Borell v. Katz, L.A Sup. Ct. No. CO62498.

In another instance, an effort was made to establish a joint venture among a number of large insurance companies and other organizations, including the AMA, to establish a private technology assessment program. The insurance companies were considering a substantial amount of funding for the venture. However, the program was never undertaken because of insurance company concerns about potential antitrust liability.

RESPONSE OF DR. SCHENKEN TO A QUESTION SUBMITTED BY SENATOR DURENBERGER

The AMA is recommending statutory changes that will permit physicians to form networks and to provide advice and recommendations to managed care plans. Recognizing that there will always be providers trying to game the system, what protection would be built into the system to achieve the principal goal of the antitrust laws -- maintaining competition -- which may not be in the providers best interest?

AMA Response -- There are two AMA proposed statutes that would modify the antitrust laws. Both are designed to prevent anticompetitive abuses by physicians who might try to take advantage of them in bad faith.

The first proposed statute, the "Physician-Health Plan Negotiations Act", would provide safe harbors from antitrust liability for physician networks that meet certain criteria. The proposed Act defines certain safe harbors, and also would provide a process whereby physician networks that do not meet the defined criteria could apply to the Department of Health and Human Services for a certification. If certified, the network would have the same kind of safe harbor from antitrust liability as networks that meet the defined criteria.

There are several safeguards built into this proposed statute that would prevent anticompetitive abuse:

1. Each of the defined networks is subject to a market power limit. The safe harbor criteria require that the number of physicians could not exceed a defined size in the market in which they operate. That way it is not possible for a single physician network to implement a market-wide price fixing conspiracy or other type of anticompetitive agreement.

2. The safe harbors for the more loosely structured networks bar the network members from threatening to boycott the payer if the network positions are not adopted by the payer, and network members are barred from sharing certain kinds of price information.

3. The safe harbors do not give the networks blanket immunity from the antitrust laws. The safe harbor is structured to authorize the activities described by the safe harbor, but otherwise the full force of the antitrust laws would apply. For example, a network would not be immune from liability for attempting to implement a market-wide price fix by conspiring with physicians or physician organizations outside of the network. That kind of activity would still be per se illegal under the antitrust laws.

4. The Department of Health and Human Services would supervise the operation of the networks that it certifies, and would place any limits on their structure and operation that it deemed appropriate.

The other proposed statute, the "Managed Care Improvements Act", would require a managed care organization (MCO) to appoint committees of participating physicians to comment on policy and operational decisions of the MCO that affect medical practice, and to allow participating physicians in the plan to develop collective positions to present to the MCO. The proposed Act prohibits the participating physicians in an MCO from boycotting the MCO if the MCO does not accept the recommendations or positions of the participating physicians. In addition, the participating physicians are not authorized to share private information with non-participating physicians.

PREPARED STATEMENT OF STEVE WETZELL

Prior to addressing concerns relative to antitrust law, it may be helpful to provide some background information about the Business Health Care Action Group (BHCAG) and how it relates to the unique nature of the Minneapolis/St. Paul medical community. The BHCAG strongly believes that the private sector can and should play a significant role in solving our nation's health care crisis. We believe we have developed one potential model for private sector based reform that can control costs while improving the quality of care received. The BHCAG is a group of sixteen, large self insured employers. This coalition currently provides health care benefits for about 175,000 people. The employers and their employees spend about $400 million annually in the community.

Although we will not discuss our mission statement in detail during oral testimony, the text has been included in this written testimony for your consideration. It is important to emphasize that a primary goal is to make our contracted health care providers accountable for defining what care is necessary to treat patients in the most cost effective manner. In addition, there is a strong emphasis on primary and preventive care as well as reduced administrative cost for delivering health care to our employees and their families.

Business Health Care Action Group
Mission Statement

The Business Health Care Action Group (BHCAG) is a coalition of Twin City employers dedicated to progressive reform of the health care system. This coalition is dedicated to reform through:

- Improved quality
- Increased provider competition
- Increased consumer knowledge and responsibility for their health care decisions
- Enhanced efficiency of health care delivery

We believe that employers who purchase health care can use their influence as a catalyst for progressive reforms, not only for those to whom we provide coverage, but also for the community as a whole. This approach to reform will benefit consumers, purchasers, and providers who delivery high quality, cost effective care. We believe that the experience gained through this initiative can be applied to health care reform on a broader basis.

Our initiative will improve quality by providing health care consumers with integrated systems of care that efficiently deliver high quality and cost effective care. The quality of competing integrated systems of care will be assessed by tracking performance relative to provider-developed practice guidelines and by outcome-based data to support continuous quality improvement of health care services.

Providers will benefit from a significant reduction in administrative duties and through access to information comparing the quality of the care they provide to that of their peers. High quality, efficient systems of care will benefit from improved market share over time, causing others to focus on the overall quality and value of their services.

Consumers and employers will benefit by consolidating information about health care consumption to determine which care systems are delivering necessary and appropriate, high quality, cost effective medical care. By pooling health care utilization data and exercising collective economic leverage, the coalition can encourage providers to develop and introduce practice parameters and use outcomes data to continuously improve the

quality of their practice. Selected providers will agree to and be held accountable for the use of practice guidelines and outcomes-based quality standards. This will support continuous quality improvement and cost containment.

Principles to which the BHCAG has agreed include:

- **Consumer responsibility for health care.** The BHCAG is dedicated to stimulating competition between integrated systems of care based on cost and quality. This will allow consumers to choose care delivery systems based on the cost and quality of care over the long term. In addition, consumers are expected to take added responsibility for managing their own health and consumption of health care resources. Co-payments and plan incentives will also promote appropriate use of health care resources.

- **Provider accountability and continuous improvement.** Development of best practice parameters, outcomes-based comparative data, and quality indicators will occur over time to accommodate continuous quality improvement. To foster physician ownership and active use of practice parameters, development of these tools should occur in a provider governed setting. Third party involvement in the health care delivery system will be minimized as much as possible. Providers will be encouraged to work in partnership with purchasers and payers to share information to identify best practice standards and outcomes data and continuously learn from their peers.

- **Common plan design and administrative structure.** All BHCAG companies will agree to common design and administration to reduce administrative and compliance issues currently faced by providers.

- **Meaningful quality and utilization data.** Clinical and population health data will be gathered over time to stimulate competition between integrated systems of care and assist providers and payers in identifying best practice standards and innovative tools to improve population health status. Data will not be used to identify "bad apples," but rather to stimulate improved quality and competition between competing systems of care.

Participating BHCAG companies began introducing a new health care plan designed around these principles effective January 1, 1993.

The Nature of the Minneapolis/St. Paul Health Care Market

Before describing some details regarding the BHCAG's approach to health care purchasing and reform, it is important to understand the unique nature of the market in which these employers purchase health care. Managed Care is not a new concept to the Twin Cities of Minneapolis and St. Paul. Organized systems of care have been evolving for many years.

At the time the BHCAG decided to engage in a group purchasing initiative, the market was dominated by Health Maintenance Organizations (HMO's) and Preferred Provider Organizations (PPO's). It is estimated that about 70% of the residents of the greater Minneapolis/St. Paul urban area are currently enrolled in various forms of 'managed care' health plans featuring contracted relationships between providers and insurance carriers or health maintenance organizations. In addition, the market has significant numbers of large

group medical practices and multi-specialty clinics. Health care costs in the Twin Cities are about 15% below the national average largely due to the impact of managed care products and organized systems of care in the market place.

However, in spite of this high penetration of managed care products, the member employers of the BHCAG still felt there was need for improvement in the quality and efficiency of the health care system. Meaningful quality data about competing health plans and provider networks was not available to consumers or purchasers. Because providers were often contracted with multiple managed care and insurance vendors, there was not a real incentive at the individual hospital or clinic level to compete for patients based on cost and quality.

In addition, managed care contracts with providers were largely based on discount fee for service arrangements. While addressing unit pricing, this approach did not get at the issue of futile and unnecessary care. In addition, like Medicare/Medicaid reimbursement policies over the past several years, the extensive use of discounts in managed care products to generate 'savings' resulted in significant cost shifting by health care providers within the Twin Cities market to participants in non-managed care (e.g. - indemnity) health plans. Medical inflation rates, while running well below the national average, still exceeded real growth in the economy.

In this environment, BHCAG decided that purchasers, working directly with preferred providers in a long term arrangement, could improve on the current health care delivery system.

The BHCAG Model for Group Purchasing

Health Care Benefits for the Participants: All sixteen companies have agreed to a common plan design and administration to reduce non-health care related expenditures. Administrative costs are estimated to be 8% - 10% of the total cost of the health plan. The plan is based on a concept called 'point-of-service.' This benefit design offers covered individuals the freedom to choose physicians which has historically accompanied indemnity type insurance plans. It also offers participants the option to use more accountable, cost effective contracted providers in exchange for higher benefit coverage. All member companies have contracted with the same network of hospitals, physicians, nurses and allied health professionals with the assistance of a large managed care organization called HealthPartners.

When using contracted providers, plan participants receive 'in-network' benefit coverage. A primary care clinic site must be designated by the participant and referrals to specialists must be made by the designated primary care provider to qualify for the higher in-network benefit coverage. Generally, clinic based services provided by a contracted provider require a $10 co-payment by the consumer. In-patient coverage is 100% after a $100 deductible. Comprehensive adult and pediatric preventive care benefits are included when contracted providers are used for these services. 'Out-of-network' benefits are generally paid at 70% with an annual limit on expenses paid by the participant.

Provider Accountability: The managed care organization with which the BHCAG is contracted has agreed to a three year guarantee on cost increases. The managed care organization assists the BHCAG with provider contracting. Contracted providers are held accountable for the cost of their care through negotiated fee schedules. Ultimately, the BHCAG hopes to negotiate an annual budget with participating providers to deliver care for plan participants. Certain changes in regulation are needed before this change can be fully implemented. This issue will be discussed later.

Accountability for quality of care and the medical necessity of services delivered is attained through the development of mutually agreed to medical practice guidelines and measures of patient outcomes. A joint purchaser/physician governed organization is responsible for all guideline development and implementation and measurement of outcomes. Data is used as a tool to teach participating health providers how to improve the quality and cost effectiveness of their care, not as a 'weapon' to search out 'bad apples.'

Joint purchaser/provider assessment of the appropriate application of new technologies has also been agreed to.

Population health will be measured over time to identify opportunities for development of guideline topics and consumer education programs to focus on keeping people well as opposed to the more traditional relationship between purchasers and providers of paying for illness.

The Consumer/Patients' Role: Both participating purchasers and providers believe that the consumer/patient has a significant role to play in solving our health care problems. Extensive investments in consumer education are anticipated. An emphasis on appropriate self-care and preventive care will be paramount in joint purchaser/provider efforts to provide participants with the tools to better manage their own health. Patients will also be held accountable for services they consume by reasonable co-payments.

Estimated Financial Impact: First year savings range from 5% to 10% compared to other managed care options in the community. Administrative cost increases are limited to CPI. If enrollment growth goals are met, administrative costs will remain flat for three years.

Aggregate cost trend guarantees are in place for three years. In addition, commitments have been made to reduce cost increases for physician and hospitals services by 1 per year relative to real growth in the economy. (For example - if medical inflation is 4% in excess of real growth in the economy in year 1, medical inflation will not exceed real growth by more than 3% in year 2.)

The Current Regulatory Environment and Its Effect on the BHCAG Project

In our view, public policy requires that federal and state governments should actively encourage innovative joint purchasing arrangements in the health care sector. The BHCAG has certain concerns relative to the current legal environment which participants confront when they explore the idea of forming a purchasing coalition. In particular, we would like to briefly share concerns about the antitrust laws and the Employee Retirement Income Security Act (ERISA.)

In general, businesspersons are not antitrust experts. But we know enough about antitrust laws to have an antitrust 'reflex' that tells us to proceed with extreme caution whenever the topic of joint activity with other firms is raised. If the joint activity under consideration promises substantial benefits, we usually ask an antitrust attorney to review the proposed venture to assure us that there is no antitrust risk.

During the course of our group purchasing effort, we have learned that antitrust law does not produce the kind of short, simple and unambiguous conclusions that business people need to act decisively. As we understand it, antitrust law involves the application of very general principles about "competition" in the real world of business. What kinds of activities are pro competitive? What kind of activities are anti competitive? These kinds of questions - although they are fascinating to lawyers - are extremely frustrating for business. Business people need clearer signals.

Fortunately, during the last few years, employers have been getting some pretty clear signals that joint purchasing arrangements in the health care sector are lawful under the antitrust laws. Last year, for example, the Director of the Federal Trade Commission's Bureau of Competition emphasized the valuable role which joint purchasing arrangements play in the health care field when he stated:

> "Large buyers and buying groups are playing a significant role in efforts to contain health care costs. These purchasers generally exert a significant pro competitive influence on health care markets. As antitrust enforcers, we welcome the pro competitive arrangements that contribute to the battle to bring health care costs under control."

We are told that recent speeches by antitrust enforcement authorities similarly conclude that joint health care purchasing arrangements should be permitted under the antitrust laws.

We are now quite comfortable with the conclusion that the BHCAG is a pro competitive venture which does not violate the antitrust laws. As we look back at the process under which we reached this conclusion with legal counsel, it must be noted that there is room for improvement. Although the public comments to which we have referred are extremely encouraging, the conclusions reached in those speeches and articles are not yet part of the law applied by the courts and do not constitute the official policy of the Federal Trade Commission or the Department of Justice. To what extent does antitrust law now reflect the "trends" which emerge from these speeches? To pose the question is to make the point that there is still too much uncertainty. The law should unambiguously reflect what some many knowledgeable people believe; that joint purchasing arrangements in the health care sector are "pro competitive arrangements which contribute to the battle to bring health care costs under control."

An additional point must be made relative to antitrust issues faced in large urban markets compared to rural and smaller communities. Although these issues are not pertinent to the BHCAG, another Minnesota based group purchasing effort in a much smaller community has faced these issues while attempting to contract with local providers in a market with limited competition. Senator Durenberger has made arrangements for this group to submit written testimony. We strongly encourage you to address the unique concerns of rural purchasers as you consider antitrust issues relative to health care reform.

Finally, we must also make a brief comment about the Employee Retirement Income Security Act of 1974 (ERISA.) As you no doubt know, ERISA partially exempts state regulation of employee welfare benefit plans, with practical effects of preempting state regulation of self-funded plans and permitting state regulation of insured plans. Although many states are aggressively pursuing meaningful market reform (including our home State of Minnesota), we believe that current protection offered by ERISA should be maintained to allow self-funded employers to continue to develop meaningful market based reform without being subject to significant state regulation.

We would like to see ERISA's preemption of state law enlarged so that, for example, if purchasing groups such as the BHCAG choose to acquire health coverage for our employees and their families under a capitation basis (an agreed to annual 'budget' between contracted providers and purchasers), restrictive state insurance laws would not apply. As you are aware, state insurance laws often contain mandated benefit requirements, as well as various taxes and assessments, that, taken together tend to retard innovation and make health care coverage less affordable. Such laws must not be allowed to hamper the

groundbreaking work of employers acting together in community interest. We suggest, therefore, that ERISA be appropriately amended to allow employer purchasing groups to buy insured coverage directly from providers without being subject to restrictive state regulation.

Thank you considering our concerns and opinions. As an active model of 'managed competition', the BHCAG would welcome the opportunity to continue to share our experience as we address the serious issue of national health care reform.

RESPONSES OF MR. WETZELL TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Q: What antitrust issues did you encounter during the start-up of your organization? Were you hindered by antitrust law? If so, how?

A: Because we represent an innovative group health care purchasing initiative, our primary concern was that we might be challenged for creating barriers to competition by pooling our purchasing power. Because we only represent about 8% of the regional health care purchasing market, legal counsel advised us that we are in compliance with the law. Thus, the primary problem caused by current antitrust law was a lack of clarity on what is permissible in the event employers choose to form group purchasing initiatives. The current law hindered us by causing a fairly detailed review by an antitrust attorney which took time and financial resources.

Q: When creating your organization, would any clarification regarding antitrust law be beneficial?

A: Yes. Clear rules defining how much market share can be represented by a group of health care purchasers contracting with select health care providers would benefit both the purchasers and providers of health care. Most reform proposals based on the principles of managed competition include some form of pooled purchaser influence on the market. Yet, the current antitrust law does not clearly define to what extent purchasers can pool their purchasing resources and offer financial incentives to select health care providers before they risk violation of antitrust law.

The key issue is not the extent of the regional health care purchasing market represented by the buyers' coalition. Rather, it is how the buyers use the pooled purchasing power to influence the health care delivery system. In a large market like Minneapolis/St. Paul, it would seem appropriate to establish guidelines regarding how much market share is ultimately controlled by competing health care provider systems. This type of guideline would benefit purchasers by establishing clear rules on how much of their health care purchasing dollars should go to any one provider system before competition is undermined. As long as purchasers spread their health care dollars across competing provider systems in a way that stimulates competition, there is no need to regulate the size of the purchasing coalition.

Q: Are there any antitrust issues that you currently face in your day-to-day operation?

A: Yes. Because we continue to experience growth in the number of employers joining the purchasing coalition, we are constantly aware that at any time we may be challenged under the current antitrust law. Although we are still in compliance with the law, any challenge could lead to an long and costly legal review. It would also have a chilling effect on our efforts to reform the health care market. Ultimately, under the current law, we may have to limit the size of our buyers' coalition. As mentioned in response to the previous question, we believe that the size of the buyers' coalition does not adversely impact competition as long as the purchasers spread their health care dollars appropriately across competing health care provider systems.

Q: How would your organization be different if it was created by state mandate?

A: This is a difficult question to answer without knowing what form the state mandate would take. However, the primary concern with a state mandate is that it would inherently involve a partial or full waiver of ERISA preemption. As large, self-insured employers, the member companies of the Business Health Care Action Group provide employer funded health care coverage in all 50 states.

Purchasing groups formed by state mandate would most likely be fully regulated by the state. This would create an excessive regulatory burden on employers covering workers and their families in a large number of states. If purchasing pools are created by mandate, we strongly advocate that the mandate and associated rules and regulations come from the federal level, and that self-insured employers be offered the option to participate in the purchasing pool on a voluntary basis.

To be certain that self-insured employers are providing appropriate health care coverage outside of the purchasing pools, we advocate a reasonable federal standard be established for minimum benefit coverage which would be applied to self-funded plans. We would welcome the opportunity to provide further input regarding what form this minimum federal standard of coverage should take.

Responses of Mr. Wetzell to Questions Submitted by Senator Hatch

Q: You suggest that there should be greater clarity in law about the pro competitive nature of buying cooperatives. Do should think that such cooperatives should be deemed conclusively legal as entities or that their actions should be exempt under antitrust law, or both? Please explain why or why not.

A: We would propose a 'safe harbor' provision to regulate the activities of buying cooperatives. As long as the buying cooperative allocates its health care dollars across competing systems of health care providers in a way which stimulates competition among provider systems, the buyers' cooperative is acting in a way which stimulates competition, regardless of the size of the buyer's cooperative.

Regulations guiding buyers groups on how much market share should be given to any one provider system would be helpful. For example, the Business Health Care Action Group currently represents about 8% of the Minneapolis/St. Paul health care purchasing market. We have contracted with a system of doctors, nurses, hospitals and other allied health professionals to deliver care for our employees and their families. A rule indicating that this type of arrangement is legal as long as a single provider system is not given more than 30% of the regional health care market by any one buying group would provide clear rules and protect the market against anticompetive activity. Additional rules regulating how much market share can be controlled by any one health care system would also be appropriate.

Of course, special consideration would need to be given in smaller mar' .ts where competing provider systems cannot realistically be developed.

Q: You indicated that before the hearing you were not so worried about antitrust risks but that after sitting through the hearing you were. Please explain what your concerns are.

A: While I have some concerns about the lack of clarity regarding permissible behavior by buying cooperatives, my greater concerns are the regulatory environment as it effects the health care provider community.

During the hearing, several points were made about potentially beneficial mergers and collaborative activities in the health care industry. For example, if providers band together to share expensive equipment, are the antitrust laws violated? To what extent can health care providers organize into accountable 'systems of care?' How much data can be shared by health care providers?

The response of the Justice Department to these questions was that providers can come to Washington or write letters asking their opinion on proposed mergers and collaborative initiatives. We face the realignment of 14% of the American economy. The Justice Department is not equipped to deal with the magnitude of change that is coming in the health care industry. Further, to add staff is not the answer. It seems much more appropriate to define the terms under which providers can organize into accountable systems of care and when collaborative efforts are appropriate. Under these clear and appropriate guidelines, the health care industry would be empowered to organize in a more competitive and cost effective fashion.

COMMUNICATIONS

STATEMENT OF THE FEDERATION OF AMERICAN HEALTH SYSTEMS

The Federation of American Health Systems appreciates this opportunity to submit for the record its comments on antitrust issues in the health care industry. The Federation of American Health Systems is the national association which represents investor-owned health systems. Our members include more than 1,400 hospitals as well as integrated health plans which insure several million Americans. Investor-owned management companies also manage under contract more than 300 hospitals owned by others.

ANTITRUST LAWS AND MANAGED COMPETITION

Health care reform requires a reassessment of the application of antitrust laws to provider organized health plans and provider arrangements with health plans. Instead of head to head competition on a hospital by hospital basis, managed competition will primarily be competition among *networks* of providers and insurers for contracts with Health Insurance Purchasing Cooperatives (HIPCs) or large employers outside the HIPC structure.

As providers organize to develop or participate in networks that provide quality, cost effective care under what will be predominately a capitated system, desired economies of scale may well result in highly concentrated provider network markets.

Some arrangements will necessitate enforcement of traditional antitrust policy, while others will warrant a new policy. The general rule should be that antitrust laws must be used to assure consumer *choice* based on quality and price competition among plans (networks). If some easing of antitrust enforcement encourages the formation of competing health plans, thus increasing consumers' choices, that should be supported; however, the antitrust laws must protect consumers against undue consolidation of and decreased competition among plans.

The issue is how to balance the trade-off between efficiencies achieved by concentration of providers into a single or few networks, versus maintaining consumer choice on the basis of quality and avoiding monopolistic market share and pricing by a large, dominant provider network.

The following examples illustrate the importance of arriving at the correct balance in applying antitrust policy:

COLLUSION/BOYCOTT

- Providers could be excluded from the networks by collusion among other providers. Several hospitals and their medical staffs organize a network and refuse to contract with any competing networks.

Through the use of exclusive dealings or contracts a network of providers could "foreclose" so much of the available supply of providers and their services that existing plan competitors or new plan entrants could be severely limited or excluded from the area. Once a provider of goods or services is protected from competition, they are insulated from the demands of patients and or payers because they are the only source for obtaining those goods or services. Antitrust laws should be maintained to the degree that prevents hospitals conspiring to exclude other hospitals from participating in a network of providers if it results in a monopoly and deprives consumers of choice among competing plans.

- Several hospitals agree to contract with an insurance plan but only if another hospital is excluded.

This type of boycott or conspiracy to constrain competition should be prohibited. Currently, unilateral decisions by insurers not to contract with a hospital, physician or other provider is allowed, however, a conspiracy to deny a hospital participation in a network would not be allowed under current antitrust enforcement. This policy

should continue. Similarly, if the medical staff of a hospital contracts with a health plan on the condition that the medical staff of a competing facility be denied preferred provider status or participation by the plan, antitrust enforcement should prevent physicians from conspiring to restrain competition.

- Several hospitals conspire to block a certificate of need sought by another hospital in order to meet contractual requirements of a health plan.

Such a conspiracy or agreement among competing hospitals to prevent a hospital from competing for a health plan contract should be prohibited. Congress should also consider a federal pre-emption of state certificate of need laws so that providers can freely compete to participate in or establish a network by being able to provide the necessary array of services for network enrollees. A capitated system will ensure that providers will offer only those beds, services and equipment that can be supported by the volume of plan enrollees.

EXCLUSIVE CONTRACTS

- Managed competition will encourage plans to obtain exclusive dealing contracts tying physicians, hospitals or other providers to a single network.

Developing a provider network already requires significant capital. If all or a substantial portion of providers in an area are already "locked up" with existing health networks, it will be extremely difficult to establish a competing network or health plan. Any new plan would have to invest significantly more to sign up physicians, hospitals and other providers to establish a viable, competing network. Therefore, inappropriate exclusive contracts impose a significant barrier to entry of more competitors.

Such barriers affect not just price and quality, but also the variety of services offered. Even with a standardized benefit package, plans could deliver the benefit package in different ways and at various costs. Innovation is the cornerstone of competition and the hallmark of American medicine. Innovation must continue to play a significant role in our health care system. Antitrust policy must assure that managed competition does not create new or heightened barriers to entry.

Neither plans nor networks should be allowed to dominate a market by obtaining inappropriate exclusive contracts with the majority of physicians and hospitals. Exclusive contracts should be limited in number relative to market domination and in duration. This allows alternative plans the opportunity to approach and the opportunity to obtain contracts with providers of health care in an area. If the use of exclusive contracting leads to a monopoly and deprives consumers of choice among competing plans, government should apply antitrust laws.

EASING ANTITRUST ENFORCEMENT

A reformed health system will require a different balancing of interests to support the goal of achieving a more efficient and effective health care system, while protecting consumer choice among plans competing on price and quality. Some cases will merit an easing of antitrust enforcement. However, few circumstances will justify a complete exemption from existing antitrust laws.

SHARED SERVICES AND MERGERS

- Several hospitals and their medical staffs organize a health plan and agree to share certain services, such as those related to expensive technology but do *not* create a monopoly.

This type of activity should be encouraged by easing antitrust enforcement. It does not limit choice of plans even though it may lessen competition for certain services if viewed solely on a hospital rather than network basis. Competition should be among plans. Shared services do not limit and can enhance plans abilities to compete with one another.

Decisions to allocate services among hospitals should be viewed in terms of the network. If it makes economic sense for the network, it should be allowed, but if it is a provider decision to achieve monopoly status or reduce their competition or keep out other networks, it should be enjoined.

- Several hospitals form a network, buy another hospital and close it.

If there is excess capacity and a sufficient number of competing plans with adequate hospital participation, such action should be allowed to contain costs and make the health care system more efficient. If, however, such action significantly reduces consumers choice among plans, it should be prohibited.

FEDERAL GUIDELINES

Providers and insurers will need guidance from the Department of Justice and the Federal Trade Commission as health reform and managed care growth encourages the development of provider networks. Antitrust enforcement should include publication of guidelines addressing concerns of these entities and a clarification of antitrust enforcement policy. These Federal guidelines should protect networks and providers from state and private challenges. Providers and networks should also have access to a pre-clearance process before they make substantial capital expenditures or risk stiff penalties developing networks not in accordance with the antitrust laws. However, the process or guidelines should not include broad blanket immunity from antitrust challenge.

CONCLUSION

Current antitrust policy views hospital activities and arrangements in isolation. The focus of antitrust policy, under a reformed system based on capitated plans, should be on competition among plans, not providers.

The organization of a capitated network, by itself, should not be viewed as an antitrust violation under current law. Sole providers, such as those in some rural areas, already have a de facto monopoly. If a competing plan tries to develop in the area and the sole provider refuses to participate, the test should be whether that is a boycott or a legitimate unilateral refusal to contract. The sole provider should not be obligated to join, but refusal should be based on economic, quality, or other reasons, not as part of an effort to achieve monopoly status for the single existing network.

As the Administration and Congress consider significant changes in the financing and delivery of health care, they must examine the applicability of current antitrust laws. With the advent of managed competition traditional antitrust prohibitions will still play an important role. However, the unique competitive environment created by managed competition requires a review of existing antitrust policy with an eye towards changes that are likely to lead to significant quality and price competition in health care markets and a more efficient health care system.

STATEMENT OF RONALD SCHIEMANN

My name is Ronald Schiemann. I am the Administrator of Quality Health Network, Inc. (QHN) a not-for-profit integrated service network located in Red Wing, Minnesota. Red Wing, Minnesota is a 15,000 population community. Our community cannot hope to have more than one hospital nor more than one multi-specialty clinic and neither can our neighboring communities. Red Wing is located between "world class" health care centers; one located in Rochester, Minnesota and the other located in Minneapolis, Minnesota, each one being an hour drive from Red Wing.

Quality Health Network is a coalition of Red Wing area employers concerned about improving the quality of medical care for their employees and controlling future increases in medical costs. Employees, employers and health care providers have an opportunity to work together at the local/regional level to support a quality managed health care system.

Our intention in developing our network was to be proactive and open in a partnership arrangement with employees, health care providers and health care regulators. In that regard, we discussed our concept with the Minnesota Department of Health in concert with our local representative and senator. We received their approval and support.

As we progressed, we were warned that the Minnesota Attorney General's Office was notified of our efforts and the result was that we were going to be stopped in our efforts because of possible antitrust violations. A meeting with the Attorney General's Office assured us that what we were doing was true competition and we received a "letter of comfort" from their office. However, a major change had to be implemented by our organization.

That change forced both our hospital and our clinic representatives to withdraw from the creation of Quality Health Network. It was the Attorney General's opinion that their involvement could be cause for antitrust violations regardless of the extent of their involvement as a provider and/or an employer.

The effects of this forced change caused considerable delay, restructuring of our organization with additional costs, changes in committee reassignments and so on. High levels of frustration on the part of the employers and health care providers were generated because of the need to communicate separately with the hospital and clinic. The situation contributed little to development of a partnership relation-

ship between the health care providers and Quality Health Network members. In addition, it severely discouraged employers and the health care providers from continuing their two year efforts in the development of our network.

Papers and periodicals state that antitrust reform is unnecessary for health care providers and employers to reach an agreement for the development of integrated networks. However, reality doesn't agree. Please take our experience to realize that current antitrust regulations were a major detriment to the development of our network.

Although current antitrust regulations caused considerable delay and costs, Quality Health Network has been established and currently servicing employees, employers and contracted health care providers. Our success has generated very strong interest by other rural communities, employer groups and health care provider networks. However, continued confusion on antitrust regulations continue to foster delays in action by these various groups.

Antitrust legislation was built to prevent a concentration of a particular product by large powers. A local community health care network like QHN offers:

- Local employers who are willing to pay what it costs for good local primary and secondary health care for their employees and their families,
- Local health care providers who make a commitment to provide local primary and secondary health care on a cost-effective basis,
- Local employees and their families who want to use a community owned or operated hospital, emergency room and clinic,
- A competitive alternative for the community's citizens to the huge third party payor organizations with their large homogeneous programs,
- A competitive choice for the citizens of the community between large metropolitan hospitals and a community operated hospital, and
- A competitive choice for the community's citizens between large metropolitan clinics and their local community-operated clinic.

Quality Health Network gives the community a chance to say that it is not satisfied with being told they are delivered the "best and most cost-effective health care" when they do not believe it. The current system requires our community to stand and helplessly watch the financial health of its local health care providers slowly drained away, until they are reduced to nothing. The resulting vacuum will allow large, highly concentrated health care providers and third party providers to step in with absolutely *no* health care competition in our community at all.

Quality Health Network is based on the following premises:

1. Proactive quality health care in terms of measurable medical outcomes and customer satisfaction is vital and will ultimately control the costs of health care.
2. Health care is a local issue and should be managed on a local level.
3. Unbundling of how health care is presently provided is necessary to eliminate the unwieldy and costly administration of the current systems.
4. Group purchasing of services and products will allow strength in negotiating for those products and services.
5. Employees, employers and health care providers must be involved in the quality and level of care given.

What works in the rural areas to promote competition is cooperation. We want to provide businesses and citizens of our community with a competitive choice between local health care and health care provided by large metropolitan health care clinics, hospitals and third party payor organizations.

We need antitrust legislation reform on both Federal and State levels that will allow rural or small community health care providers to take a cooperative role in the development of integrated service networks. We need assistance in the interpretation of antitrust regulations on a Federal level rather than depend upon estimates of what the Federal response will be to an action.

An equally disturbing situation exists for employees and employers who are too small to participate in an integrated service network without the development of a Multiple Employer Trust arrangement.

Based on our legal counsel advice, we have determined that Multiple Employer Trust regulations are so onerous that we are forced to exclude the smaller employers and individuals from participation in our network at this time. This prevents individuals and smaller employers from realizing the same options and flexibility now available and enjoyed by larger employers.

Regulations on Multiple Employer Trust arrangements must be reformed to the point where they encourage rather than discourage network building in rural areas.

A quality, effective, financially sound hospital and clinic are vital to the economic well being of rural communities. In addition to providing high quality care to the

community, they play a pivotal role as an inducement for firms considering expansion into the community as well as an employer role in providing an economic contribution to the community.

Involvement by employees, employers and health care providers and incentives for these parties are vital to a successful partnership arrangement needed in order to create a local, rural health care network. Antitrust reform is crucial to the creation of that successful partnerships arrangement.

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